

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MAYER JACK ABELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5, 1983</b>		2b. HOUR <b>9:25A</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 5, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JULIUS ABELL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHANNA RUDNITZKY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-07-0765</b>		17. INFORMANT <b>MRS. ROSE ABELL</b> <b>3522 LANGREHR RD., APT. 1-B #21207</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4148

IMMEDIATE CAUSE (a)

ventricular fibrillation

DUE TO, OR AS A CONSEQUENCE OF

(b)

myocardial ischemia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>83</u> , to <u>1/5</u> , 19 <u>83</u> , the (1) (two) last saw the deceased alive on <u>1/5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert I. Garver, Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/5/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT I. GARVER, JR.</b>		22d. ADDRESS <b>JOHNS HOPKINS HOSP DEPT. OF MED.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JAN 7 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00636	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALEXANDER ADAMS						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 30 1983		2b. HOUR M			
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 25 35	6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 1 31 1983		2d. HOUR 11:53 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1918 McCulloh St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1918 McCulloh St 21217					
14. FATHER'S NAME FIRST MIDDLE LAST Robert Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Maggie Adams 1734 N. Pulaski St							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism with malnutrition</u> 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 2-1-83					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/7/83		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc.				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 2 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>			

RECEIVED  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315



Handwritten notes and signatures, including a large 'M' and a signature that appears to be 'M. J. ...'. There are also some illegible scribbles and marks.

2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00637	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony Ronnell Adams										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR HOUR 1 23 19 83 M	
3. SEX M	4. RACE E	5. DATE OF BIRTH MONTH DAY YEAR 8 31 80		6. AGE (IN YEARS LAST BIRTHDAY) YRS 2	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 23 19 83		2d. HOUR 10:44 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2905 Riggs Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2905 Riggs Ave. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Donnell Adams					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marilyn Batty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Marilyn Adams 2905 Riggs Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8950 IMMEDIATE CAUSE (a) Smoke & soot inhalation & Acute carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10:40 M. 1 23 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2905 Riggs Ave. Baltimore Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/24/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/27/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Chatman-Harris FH 1701 McCulloh St.						25a. DATE REC'D. BY REGISTRAR JAN 25 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

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W. H. C. S. H. A. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 6 3 8			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES 3 ADAMS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01/03/83</b>		2b. HOUR <b>7:30p</b> <sup>M</sup>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-8-1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77 yrs.</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Turn Leader</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Adams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola L. Wasowicz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>212-05-6982</b>		17. INFORMANT ADDRESS <b>21220 James C. Adams 6919 University Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>anteroseptal myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>congestive heart failure</b>							
19a. DATE OF OPERATION <b>1/3</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (2) this hospital attended the deceased from <b>1/3</b> 19 <b>83</b> to <b>1/3</b> 19 <b>83</b> , that (1) (we) lost saw the deceased alive on <b>1/3</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.							
23a. SIGNATURE <b>Robert I. Garver, Jr.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/3/83</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT I. GARVER, JR</b>				23c. ADDRESS <b>JOHNS HOPKINS HOSP DEPT OF MED</b>			
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23e. DATE <b>1-6-83</b>		23f. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23g. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b>				25. REC'D. BY REGISTRAR <b>51983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Garver</b>	
24b. ADDRESS <b>3331 Brehms Lane, Balto., Md.</b>				25c. DATE <b>2-21-83</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00639			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR 1 26 83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. ADAMS SR.				2b. HOUR 4:16a.m.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 26 40		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LOADING TRUCKS		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY --- 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 331 S. SMALLWOOD STREET, 21223			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY C. ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA L. HERSHEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 217-38-0245			
17. INFORMANT ADDRESS ANNA L. ADAMS 803 REGIS COURT, 21227				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) Hepatic Encephalopathy (b) Chronic alcoholism (c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 2							
19a. DATE OF OPERATION 29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-9-83, to 1-26-83, that (I) (we) last saw the deceased alive on 1-23-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Qui Dien Huynh				DEGREE		22c. DATE SIGNED 1-26-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) QUI DIEN HUYNH				22e. ADDRESS ST. AGNES HOSPITAL; 900 S. CATON AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 01-27-83		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. ADDRESS 21229				25a. DATE REC'D. BY REGISTRAR JAN 28 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00640

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Emily D. Allen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 83</b>			2b. HOUR <b>10:20</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 9 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER-BALTIMORE PUB SCHS</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>					13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13d. STREET ADDRESS <b>5906 LEEWOOD AVE</b> <b>21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK DOUGLAS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARTELIA BROWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-24-6679</b>		17. INFORMANT ADDRESS <b>REV GEORGE R. ALLEN 5906 LEEWOOD AVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5860 IMMEDIATE CAUSE (a) Cardiac shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Renal Failure; Hypoxic Brain Damage Systemic Lupus</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15</b> 19 <b>83</b> , to <b>Jan 17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 17</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dean M. Leland</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1-17-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PK</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE COUNTY, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>NUTTER FUNERAL HOME</b>					ADDRESS <b>3035-37 W. NORTH AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10:30:00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 00641						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Goldie M. Allison					January 27, 1983				2 P. M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 20, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1515 Gleneagle Road (21239)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY -- 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1515 Gleneagle Road (21239)				
14 FATHER'S NAME FIRST MIDDLE LAST William Milton Ward					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Martin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17 INFORMANT ADDRESS Mr. John Allison-1515 Gleneagle Rd. 21239							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease 54 YEARS						
					DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Osteoarthritis, generalized; CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 5/1/81, 19 to 1/27/83, 1983, that (I) (we) last saw the deceased alive on 1/24/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert T. Parker M.D.					DEGREE			22c. DATE SIGNED 1/28/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. PARKER M.D.					22e. ADDRESS GOOD SAMARITAN HOSPITAL 21239						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home					25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE FEB 3 1983 John E. Cawley						

A. Alan Seitz Funeral Home 310 Roland Ave.

Burial 1/31/83 Woodlawn Cemetery Baltimore, Maryland

No - - - 513-62-2103 Mr. John Allison-1515 Glenesale Rd. 51232

William Milton Ward Frances Martin

Maryland - - - Baltimore xx 1515 Glenesale Road (51232)

Baltimore 1515 Glenesale Road (51232) Housewife - - -

Maryland U.S.A. I Baltimore city

Female White March 20, 1892

Goldie M. Allison January 27, 1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 6 4 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>OWEN A. ALM</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 24, 1983</b>		2b. HOUR <b>2:31A M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 7, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EDGEWOOD NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERINTENDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MFG. STREET SIGN</b>			
13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>4 GWYNN LAKE DR. 21207</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>OLE N. ALM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE N. ?</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-36-96376</b>		17. INFORMANT ADDRESS <b>FORREST R. GABLER 6600 YORK RD. 21212</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <b>2765 IMMEDIATE CAUSE (a) Shock -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 days.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Severe depression Distasteful Hypertrophy</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 7, 1983</b> , to <b>Jan 24, 1983</b> , that (1) (we) last saw the deceased alive on <b>Jan 14, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <b>JOSEPH W. ZEBLEY 3rd.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-24-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>3809 GREENMOUNT AVE.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1983</b>							
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00643

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MOLLIE ALSOP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-30-83</b>		2b. HOUR <b>6:40 A.M.</b>		
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 6 40</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES ALSOP</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HENRIETTA GREEN</b>		13e. STREET ADDRESS <b>930 PRESIDENT ST. A-4</b>		13f. CITY OR TOWN <b>21403</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLES BELT 2042 Parker Dr.</b>		17b. ADDRESS <b>INPATIENT REGISTRATION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>PULMONARY EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>FLUID OVERLOAD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SYSTEMIC LUARS ERYTHEMATOSUS; RIGHT PNEUMONECTOMY; CHRONIC RESTRICTIVE PULMONARY INSUFFICIENCY</b>			
19a. DATE OF OPERATION <b>1/29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RIGHT PNEUMONECTOMY</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>83</b> , to <b>1/30</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/30</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>CU</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GLW ARNAUD</b>		22e. ADDRESS <b>UNIVERSITY HOSPITAL</b> <b>22 S. GREENE ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2-7-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1983</b>			

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RECEIVED  
FEB 19 1963

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RECEIVED  
FEB 19 1963  
J. Edgar Hoover

RECEIVED  
FEB 19 1963  
J. Edgar Hoover

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

00644

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William A. Alston, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 1 4 83		2b. HOUR M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 2 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1315 Stonewood Road	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland		12b. COUNTY Baltimore		12c. CITY OR TOWN Baltimore	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 1315 Stonewood Road 21239			
14. FATHER'S NAME FIRST MIDDLE LAST William A. Alston, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21912-6776		17. INFORMANT ADDRESS Jacqueline Alston 1315 Stonewood Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 1479 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Metastatic ca of nasopharynx</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 months</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>82</u> , to <u>January 4</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>January 4</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death.					
22b. SIGNATURE <u>E. Lignos</u>		DEGREE		22c. DATE SIGNED 1-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evangelos LIGNOS M.D.		22e. ADDRESS 201 E. University Pkwy, 21218			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/8/83		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Wm. C. march F/H Inc. 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 10 1983	
				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

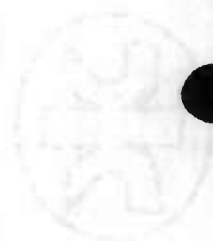
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amon, MIEZOUX			2a. DATE OF DEATH MONTH DAY YEAR January 16, 1983		2b. HOUR 12:05AM
3. SEX Male	4. RACE African	5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1955	6. AGE (IN YEARS LAST BIRTHDAY) 27 years YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ivory Coast, Africa	7b. CITIZEN OF WHAT COUNTRY? Africa	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 15 Eager Street 21201
14. FATHER'S NAME FIRST MIDDLE LAST Julian Kacou Amon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Ayneki Boa		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 999-00-0443	17. INFORMANT ADDRESS Medical Records Department Balto., Md. 21201 Maryland General Hospital 827 Linden Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tonsillar Herniation of the Cerebellum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the rectum with metastases to the Brain and the Bone XXXXXXXXXXXXXXXXXXXX XX					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (his hospital) attended the deceased from 1/14/83 to 1/16/83, to 1/16/83, that (1) (we) lost saw the deceased alive on 1/14/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE FANN C. VELLA, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/16/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FANN C. VELLA - CAMILLERI, M.D.		22e. ADDRESS 827, LINDEN AVE. BALTO, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/3/83	23c. NAME OF CEMETERY OR CREMATORY Abengourou Cem.		23d. LOCATION CITY OR TOWN COUNTY Abengourou, Ivory Coast West Africa	
24. FUNERAL DIRECTOR NAME Chatman-Harris 1701 McCulloh Street		25a. DATE REC'D. BY REGISTRAR JAN 21 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the funeral director to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

BP 10



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 0 0 6 4 6	
1. DECEASED NAME (TYPE OR PRINT) <b>MARCELLE LYNN ANDREWS</b>								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-25-83</b>		7b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 17 65</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>17 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>1-25-83</b> 7a. HOUR <b>4:59P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2022 Jasmine Road 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles L. Andrews, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth P. Pindell</b>				17. INFORMANT <b>2022 Jasmine Road-Baltimore</b> ADDRESS <b>Charles L. Andrews, Sr. MD. 21222</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>212-94-9638</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8147</b> IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:35P 1-22-83</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by an auto</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Lynch Rd. &amp; Harold Rd. Dundalk, Maryland</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b> M.D.				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>1-26-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>1/28/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>			



100-443887-100  
100-443887-100  
100-443887-100



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louise Nancy Anselmi</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 13 83</b>			2b. HOUR MIN. <b>1:13a</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/12/1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WILGAS, PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6426 O'DONNELL ST. 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BIAGIO GUIDO</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ASSUNTA UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>076.14.9864</b>		17. INFORMANT <b>EUGENE ANSEMI</b>		ADDRESS <b>6908 CIRCLE AVE. BALTO., MD. 21220</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Myocardial infarction last year - old history of ventricular arrhythmias</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>82</b> , to <b>1/13</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alison Freifeld</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/13/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALISON FREIFELD</b>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/17/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DHMH - 17  
(VR A15 ME (5))  
20M 4/82

999995  
(VR A)



RECEIVED

PROVIDENCE

12

12

12



12

12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Earl WILLIAM APPEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-8-83</b>		2b. HOUR <b>355<sup>PM</sup></b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 31, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital Corp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stamp - maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-- --</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John -- Appel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie -- Brendan</b>		13e. STREET ADDRESS <b>1100 S. Decker Ave. (21224)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-- -- 216-09-7885</b>		17. INFORMANT <b>Charles Hodges</b>		ADDRESS <b>762 214th St. (21222)</b>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that if (this hospital) attended the deceased from <b>1-8-83</b> to <b>1-8-83</b> , that (I) <del>was</del> last saw the deceased alive on <b>1-8-83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did) (do not) view the body after death.							
22b. SIGNATURE <b>Allen A. Cioffredo</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen A Cioffredo</b>				22e. ADDRESS <b>606 N BOND, BALTIMORE, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 11, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore -- Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave. (21231)</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. L...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 of 1

BP



7310. *Arctostaphylos*

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BP

DHMH-16 50M 1/81  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marie Elizabeth Appelt</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 9, 1983</i>		2b. HOUR <i>5 P.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 23 06</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i>		8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
11. CITY OR TOWN OF DEATH <i>Baltimore</i>		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Long Green Nursing Home</i>		13. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>259 South Ellwood Ave. 21205</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Appelt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Punte</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-10-3310</i>		17. INFORMANT ADDRESS <i>Dorothy Nuth 538 N. Luzerne Ave 21205</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio Vascular Disease</i> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>21 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Diabetes Mellitus</i> <i>2 1/2 yrs</i>						
19a. DATE OF OPERATION <i>June 20, 1961</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diabetes Mellitus</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 20, 1961</i> to <i>Jan 9, 1983</i> , that (I) (we) lost saw the deceased alive on <i>Jan 9, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>W. Grafton Hensperger</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/10/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Grafton Hensperger</i>		22e. ADDRESS <i>214 Medical Arts Building</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-12-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. City Maryland</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>C.S. Zeiler &amp; Son Inc. 901 S. Conkling Street</i>				
25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>				

1-15-73  
J. J. S. & Son Inc. 101 S. 10th St. St. Paul, Minn.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 5 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PEGGY L AQUINO</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>83</b>			2b. HOUR <b>10<sup>30</sup></b> M					
3. SEX <b>F Female</b>		4. RACE <b>C White</b>		5. DATE OF BIRTH MONTH <b>Mar</b> DAY <b>23</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>---</b> DAYS <b>---</b>		8. IF UNDER 24 HRS HOURS <b>---</b> MIN. <b>---</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
13. CITY OR TOWN OF DEATH <b>Baltimore</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>			16. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Maryland</b> 17b. COUNTY <b>---</b> 17c. CITY OR TOWN <b>Baltimore</b>			18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			19. STREET ADDRESS <b>934 S. Clinton Street 21224</b>					
20. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b>Lowery</b> LAST <b>---</b>						21. MOTHER'S MAIDEN NAME FIRST <b>Pearl</b> MIDDLE <b>Freeburger</b> LAST <b>---</b>					
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			23. SOCIAL SECURITY NO. <b>---</b>			24. INFORMANT ADDRESS <b>Elsie Oppel 934 S. Clinton St. 21224</b>					
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4280</b> IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>---</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>											
26. DATE OF OPERATION			27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. <b>---</b> 19 <b>---</b>			32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
33. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35. LOCATION STREET CITY OR TOWN COUNTY STATE			36. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> 19 <b>83</b> , to <b>1/2</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/2</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
37. SIGNATURE <b>Dr. Dennis McDonald M.D.</b>			38. DEGREE <b>---</b>			39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			40. DATE SIGNED <b>1/3/83</b>		
41. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. DENNIS McDONALD M.D.</b>			42. ADDRESS <b>MERCY HOSPITAL</b>								
43. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			44. DATE <b>Jan 6, 83</b>			45. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>			46. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY <b>---</b> STATE <b>---</b>		
47. FUNERAL DIRECTOR NAME <b>Dippel Funeral Homes, Inc.</b> ADDRESS <b>7110 Belair Road, Baltimore, Md.</b>						48. DATE REC'D. BY REGISTRAR <b>JAN 5 1983</b> REGISTRAR'S SIGNATURE <b>Sam J. Carver</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 6 5 2			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Garnelle S. Armstrong				1 23 83				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Black		8 3 29		53 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		3506 Sequoia Avenue									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3506 Sequoia Ave. 21215			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Walter H. Smith				FIRST MIDDLE LAST Estelle Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				213-26-9598		Gwedolyn Armstrong 3506 Sequoia Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 5 yrs</u> <u>~ 20 yrs</u> <u>~ 3 yrs</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/2/83</u> to <u>Jan 19 83</u> , that (I) (we) lost saw the deceased alive on <u>11/2/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>1/24/83</u>	
22b. SIGNATURE <u>James J. Carey</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James J. Carey</u>				22e. ADDRESS <u>803 N. Eutan St</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		1/28/83		Arbutus Mem. Pk.		Arbutus Md.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H Inc. 1101 E. North Ave.				JAN 25 1983		<u>James J. Carey</u>					

BP

THE UNIVERSITY OF CHICAGO  
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540 EAST 57TH STREET  
CHICAGO, ILL. 60637

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10% COTTON



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00653

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD A ARMSTRONG</b>			2a. DATE OF DEATH MONTH DAY YEAR 01 15 83			2b. HOUR 822 P.M.	
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR 03 08 29		6. AGE (IN YEARS LAST BIRTHDAY) 53		IF UNDER 1 YEAR MONTHS DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Packaging</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>1180 Newfield Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomes T. Armstrong</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Paulina E. Farson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>218-22-9401</b>		17. INFORMANT ADDRESS <b>Mrs. Joan Armstrong Same as # 13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 2 DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEFT + RIGHT CORONARY ARTERY THROMBOSIS</b>		<b>~ 2 DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROSIS</b>		<b>YEARS</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>JAMES E TAYLOR</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES TAYLOR</b>		22e. ADDRESS <b>ST. AGNES HOSPITAL, BALTO, MD 21229</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathadral Cemetary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Erroy M. &amp; Russell C. Witzka Funeral Home</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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07-0018

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Abstract

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00654			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR		2b. HOUR		
Mary Arvin			B			13 19 83			1 13 19 83		10:08 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Fe		Black		3 22 05		77 YRS.		MONTHS DAYS HOURS MIN.				1 13 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTO. Md.			U.S. A.			WIDOWED			DIVORCED			Baltimore City MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			University Hospital			Md. Class Worker			Glass				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
Md.						BALTO			YES NO			723 N. CAREY ST. 21217	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
William Morgan			Iola Peaco										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No						Mrs. Bertha Robinson			3413 Sunko Ct.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:													
8149 IMMEDIATE CAUSE (a) Multiple Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES X NO				
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
X			9:40x 1 13 19 83			subject struck by bus							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION							
WHILE AT WORK NOT WHILE AT WORK X			Street			108 N. Howard St., Balto City, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from:													
Natural causes Accident X Suicide Homicide Undetermined manner													
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED							
Hormez R. Guard, M.D.			M.D. Assistant			1/13/83							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS										
Hormez R. Guard, M.D.			111 Penn St., Balto., Md.										
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
BURIAL			1/20/83			King Mem. Park			Randallstown, Md.				
24. FUNERAL DIRECTOR			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
A.S. A. MORTON & SONS			1701 LAURENS ST.			JAN 17 1983			John J. G... ..				

(M)

100-100000

(M)

John G. ...

JAN 1 1963



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

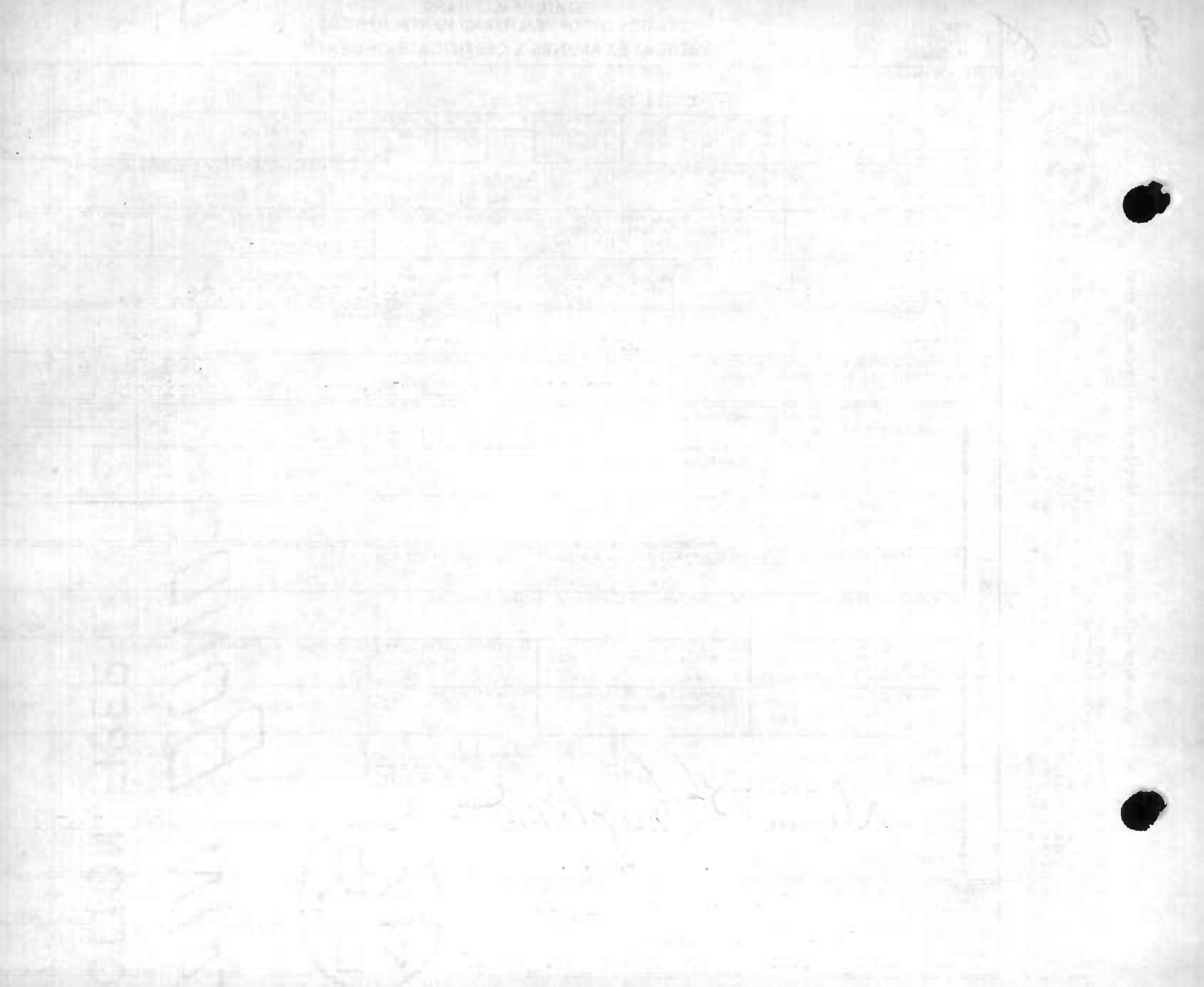
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Anna		Veronica		Austin				1		20		1983					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	7 2 11		71 YRS.						1		20		1983		8:35 P.M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.						Baltimore City,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Baltimore City Hospitals						Housewife									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS											
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3938 Old N.Pt. Rd. 21222									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
Emory		Chernan		Mary		Kohat											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
No				216-28-3139				300 Ridge Ave Louis Chernan-New Kensington, PA.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
22b. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Dennis F. Smyth, M.D.				Assistant				1-21-83									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				1/24/1983				Meadowridge				Dorsey Howard Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222								JAN 25 1983									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Viola M. BABKA</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>17</b> YEAR <b>82</b>		2b. HOUR <b>229 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>14</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTO. GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cleaning</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Offices</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>	13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1713 JACKSON St. Balto. Md.</b>	
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE <b>Taylor</b> LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>UNK.</b> MIDDLE <b></b> LAST <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>27-03-0781</b>		17. INFORMANT ADDRESS <b>Mrs. Helena M. List, 5704 Gischel St. Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Jan 17 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 17 82</b> to <b>Jan 17 82</b> , that (I) (we) lost saw the deceased alive on <b>Jan 17 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hector Silva</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HECTOR SILVA</b>		22e. ADDRESS <b>3001 S. HANOVER ST BALTO, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 20, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>			
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home, 130 E. Ford Ave. Balto. Md.</b>		25. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

MEDICAL CERTIFICATION



APR 19 1944

BARB

VIOLA

Female

10 1/2

Barb

10 1/2

Barb - Taylor

Barb - Taylor

NOTE: Barb - Taylor

At present Barb - Taylor

REAR NOTION 2800

JAN 13 1943

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 5 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES A. BACKOF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 3, 1983</b>		2b. HOUR M <b></b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 16, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6000 THE ALAMEDA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AGENT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>			13b. COUNTY <b></b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY J. BACKOF</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA TALKEMEIER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2 214-18-3965</b>		17. INFORMANT ADDRESS <b>MRS. Eloise M. Backof 6000 THE ALAMEDA</b>	

18. CAUSE OF DEATH (Enter only one cause per line on (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4292**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Diabetes, Spinal muscular Atrophy**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>79</b> , to <b>3-3</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Donato A. Vargas Jr</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONATO A. VARGAS JR</b>		22e. ADDRESS <b>6010 York Rd Baltimore, MD 21211</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JAN 6, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>6 1983</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1900, 10, 10

1900, 10, 10

RECEIVED

RECEIVED

1900, 10, 10

1900, 10, 10

1900, 10, 10

1900, 10, 10

1900, 10, 10

1900, 10, 10

1900, 10, 10

1900, 10, 10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE) FIRST MIDDLE LAST MORTON <i>MARTIN</i> LEOPOLD <i>BAEHR</i>			2a. DATE OF DEATH MONTH DAY YEAR 1 22 83		2b. HOUR 4 <sup>35</sup> / <sub>P.</sub> M.
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 05 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTO CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. STATE MD			13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	
14. FATHER'S NAME FIRST MIDDLE LAST SIMON BAEHR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA BEMACK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WII-NAVY 068-01-5174		17. INFORMANT ADDRESS MRS. BESSIE BAEHR 3714 BARTWOOD RD. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-21</i> 19 <i>83</i> to <i>1-22</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1-21</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Elio Saul Novoa</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elio Saul Novoa		22e. ADDRESS SINAI HOSP			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 24, 1983	23c. NAME OF CEMETERY OR CREMATORY BNAI REUBEN		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR JAN 26 1983		
			REGISTRAR'S SIGNATURE <i>John J. Conner</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 6 5 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH LUCY BAILEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 15 83</b>				2b. HOUR <b>5:37 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 18 46</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HANOVER PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Deaton Medical Center</b>				12a. USUAL OCCUPATION (OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21204 921 Cromwell Bridge Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Reigle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Herman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Ronald R. Stokely 921 Cromwell Bridge Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1550 IMMEDIATE CAUSE (a) POSSIBLE LIVER CANCER</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>PAST STROKE. DIABETES</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 15</b> , 19 <b>83</b> , to <b>JAN 15</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>JAN 15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Frank R. Jackson</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/16/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK R. JACKSON</b>				22e. ADDRESS <b>UNIV. OF MD HOSP. FHC</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-18-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Glen Burnie Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Road</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 18 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			

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BAILEY, HAROLD

TO HOSPITAL OR ATTENDING PHYSICIAN: The undersigned hereby certifies that the death certificate was executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 5, and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold C. Bailey Jr.			2a. DATE OF DEATH MONTH DAY YEAR Jan 16, 1983		2b. HOUR 3:00P				
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1975		6. AGE (IN YEARS LAST BIRTHDAY) 7 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Delaware		13b. COUNTY Kent		13c. CITY OR TOWN Smyrna		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D.2. Box 1019	
14. FATHER'S NAME FIRST MIDDLE LAST Harold C. Bailey Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Cross		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO.		
17. INFORMANT Harold C. Bailey, Sr. - Smyrna Rd			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4809 IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) progressive hypoxemia 6 days DUE TO, OR AS A CONSEQUENCE OF: (c) presumed viral pneumonia 10 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: status post bone marrow transplant for acute lymphoblastic leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1/7, 19 83, to 1/16, 19 83, that (I) (we) lost saw the deceased alive on 1/16, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anne M. Murphy				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anne M. Murphy				22e. ADDRESS Dept Pediatrics Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)			
Burial		1/20/83		Odd Fellows Cm		Smyrna-Kent Del			
24. FUNERAL DIRECTOR Robert C. Hutchison				ADDRESS Middletown, Md		25a. DATE REC'D. BY REGISTRAR JAN 20 1983			

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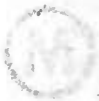
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 6 6 1	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>James Bailey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 3 83</b>		2b. HOUR <b>M</b>
3. SEX <b>male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 26 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>430 E. 20th Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>		13e. STREET ADDRESS <b>2517 E. Federal Street 21213</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Shirley Ransome 2901 E. Federal St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1890 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Cell Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diagnosed March 1982</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 15, 1982</b> to <b>Dec 31, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Dec 31, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert H. Levitt MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/6/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert H. Levitt</b>		22e. ADDRESS <b>Lock Raven VA Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/10/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mayo Grove Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mayo Va.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. Northa venue</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>KEASTER BAILEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 10 83</b>			2b. HOUR <b>7:12 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 8 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL OF BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BALTIMORE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2503 Violet Avenue 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Bailey</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Johnson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-05-7425</b>		17. INFORMANT ADDRESS <b>Beatrice Davis 2503 Violet Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> <b>2762</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metabolic acidosis &amp; CRF, sequel</b> (c) <b>probable ruptured brain abscess</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>probable ruptured brain abscess &amp; meningitis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 19 <b>83</b> , to <b>Jan 10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Elizabeth L. Simon</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. L. Simon</b>				22e. ADDRESS <b>SINAI HOSP. OF BALTIMORE MD 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 12 1983 John J. Carroll</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIOLETTA E. BAILEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 09 83</b>			2b. HOUR <b>7 52 P M</b>	
3 SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 5 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL E.R.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John R. Wilson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Yeakel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-09-6391</b>		17. INFORMANT ADDRESS <b>Arthur H. Bailey 1908 Parksley Ave. 21230</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4100**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **AS HD**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

**M.I. cor disect arrest**  
**7 years**  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Nezhat Turkman</b>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>1/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NEZDAT TURKMAN, M.D.</b>		22e. ADDRESS <b>112 CHARTLEY DRIVE; REISTERSTOWN, MD.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/13/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>	25b. REGISTRAR'S SIGNATURE <b>Sam J. Caniff</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Form with multiple sections and fields, including a header area with "UNITED STATES" and "DEPARTMENT OF THE ARMY". The form contains various checkboxes, text boxes, and a large section for "REMARKS" or "DESCRIPTION". The text is faint and mostly illegible.

Handwritten notes and markings on the right margin, including a large "E" and other illegible characters.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300664

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOAN BAIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 21 83</b>			2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>98</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ALPAC</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>1033 Maiden Choice Lane 21229</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bisset</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Collie</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>014-03-2252</b>		17. INFORMANT ADDRESS <b>Barbara J. Mongold 2925 Summit Circle 21043</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140 Cardiac Arrest</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic Heart Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1983</b> to <b>Jan 21 1983</b> , that (I) (we) lost saw the deceased alive on <b>Jan 19 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James J. Nolan</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James J. Nolan, M.D.</b>			22e. ADDRESS <b>1 Mallow Hill Rd Baltimore, Md 21209</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/24/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>			24b. ADDRESS <b>21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text: "Handwritten text" and "Handwritten text"

Handwritten text: "Handwritten text"

Handwritten text: "20% COIL"





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8300665			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Albert Baker Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 2, 1983</b>				2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 4, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>91</b>		IF UNDER 24 HRS. HOURS MIN. <b>91</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Mill</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2095 Rock Rose Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Albert Baker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Montazuma Grant Hodggers</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213 05 0556</b>		17. INFORMANT NAME ADDRESS <b>Bertha Baker same</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHERO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHERO SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>4100</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>4/24/82</b> to <b>4/2/83</b> , and that (2) in my opinion death occurred on the date and hour and from the causes stated above (1) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)													
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Meredith Smith</b>				22c. ADDRESS <b>1900 E. Northern Parkway</b>				22d. DATE SIGNED <b>4/4/83</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Burgee Funeral Home 3631 Falls Road 21211</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8300666				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD FELIX BAKUTIS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>01 14 83</b>			2b. HOUR <b>9:19 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 13 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL - E.R.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABILITY AUTH-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SOCIAL SECUR-</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>LANSDOWNE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2410 ALMA ROAD, 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL BAKUTIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>		16b. SOCIAL SECURITY NO. <b>216-01-6711</b>		17. INFORMANT ADDRESS <b>VIRGINIA P. BAKUTIS 2410 ALMA ROAD, 21227</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1850 IMMEDIATE CAUSE (a) Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DOA</b> <b>12/14/82</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>None</b>									
19a. DATE OF OPERATION <b>11/24/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Prostate</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 5 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1001 PINE HEIGHTS AVENUE, 21229</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23/82</b> , 19 <b>82</b> , to <b>1/14</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>12/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert G. Hennessy</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT G. HENNESSY, M.D.</b>				22e. ADDRESS <b>1001 PINE HEIGHTS AVENUE, 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>		23b. DATE <b>01-17-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

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1972-10-11



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1972-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Wesley Ballard			2a. DATE OF DEATH MONTH DAY YEAR Jan 24 83		2b. HOUR 3 58 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 12 49		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver/Salesman	12b. KIND OF BUSINESS OR INDUSTRY Tractor Trailer	
13a. STATE Maryland	13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1715 Light St. Balto. Md. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Percy L. Ballard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence --- Conway			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) Peace Time 217-09-7670		17. INFORMANT ADDRESS Mrs. Mildred L. Ballard, Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Acute bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) COLD.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hx of Pulmonary Tbc					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 83, to 1/24, 19 83, that (I) (we) last saw the deceased alive on 1/24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Maureen L. Durkin		DEGREE MD		22c. DATE SIGNED 1/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAUREEN L. DURKIN		22e. ADDRESS 3001 S. Hanover St. Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 29, 1983	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co. Maryland	
24. FUNERAL DIRECTOR NAME McGully Funeral Home, 130 E. Fort Ave. Balto. Md.		25a. DATE REC'D. BY REGISTRAR JAN 26 1983		25b. REGISTRAR'S SIGNATURE John J. Cariff	

BP



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "NOTICE" and "CITY" are visible.]*

*[Faint text at the bottom of the page, possibly a footer or additional notes.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 6 6 8	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>George L. Ballengee</i>						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 28 06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wayne, West Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>City Hospital</i>				17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		17b. KIND OF BUSINESS OR INDUSTRY			
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Ohio</i> 13b. COUNTY						13c. CITY OR TOWN <i>Ironton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2725 S. Fourth Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Carraway</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Kate Saddler</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>280-50-2654</i>		17. INFORMANT ADDRESS <i>Mr. Charles F. Ballengee Reisterstown</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4360</i> IMMEDIATE CAUSE (a) <i>cardiopulmonary collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary vessel accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Md.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/26</i> , 19 <i>83</i> , to <i>1/30</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>1/26</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>W. H. Hall</i>						DEGREE		22c. DATE SIGNED <i>1/30/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. H. Hall</i>						22e. ADDRESS <i>Belt City Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Feb. 2, 83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Elmwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wayne West Virginia</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Eline Funeral Home Reisterstown, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 2 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

MEDICAL CERTIFICATION



150 & 151 John & David



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00669

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Alice M. Bancroft		MONTH DAY YEAR 1/3/83	
2b. HOUR 5:01 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
F	W	MONTH DAY YEAR 3 9 08	74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore City	mercy Hospital Inc.	homemaker	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
md.	Balto Co.	Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	13e. STREET ADDRESS	
John Lessner	Bertha Smallwood	6401 Loch Raven Blvd. 21239	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
unknown	212-07-3448	Frederick Bancroft	6401 Loch Raven Blvd. 21239
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic coronary artery disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Y-rs. Y-rs. Y-rs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 19 75 to 1/3 19 82, that (1) last saw the deceased alive on 1/3 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (b) I did not view the body after death.			
22b. SIGNATURE Louis E. Grenzer		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/3/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis E. Grenzer		22e. ADDRESS 1101 N. Calvert St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/6/83	Druid Ridge Cemetery	Balto. Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE	
		JAN 5 1983 [Signature]	

MEDICAL CERTIFICATION

Burial

1/6/33

Irish Ridge Cemetery

Balto.

Maryland

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Louis BARBER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 23, 1983</b>			2b. HOUR <b>3:50A M</b>			
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>833 Druid Park Lake Dr. 21217</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Barber</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Olivia Brown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-28-6749</b>		17. INFORMANT ADDRESS <b>Sarah L. Barber 833 Druid Park Lake Drive</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1490</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Pharynx</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>January 18 1983 to January 23 1983</b>							
22a. I certify that (X) (this hospital) attended the deceased from <b>January 23 1983</b> , to <b>January 23 1983</b> , that (X) (we) lost saw the deceased alive on above, (X) (we) did not view the body after death.											
22b. SIGNATURE <b>Robert W. Nudelman</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Nudelman, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore CO Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>					



COIL  
100%  
CHILE

WATSON 44100-1101 E. NORTH AV

of Maryland General Hospital

Robert A. Johnson, M.D.

January 23, 1953

January 15, 1953

January 23, 1953

Department of the Bureau

Administration of the

Maryland General Hospital

Self-insurance

Self-insurance

January 23, 1953

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 00671	
1. DECEASED NAME (TYPE OR PRINT) <b>Viola Barber</b>								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		2b. HOUR	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 25 06</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>76 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 3 19 83</b>		7d. HOUR <b>7:42 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2708 E. Chase St. 21213</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charlie Hicks</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/a</b>		17. INFORMANT ADDRESS <b>Marie Brown 2708 E. Chase St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margareta Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER <b>DATE SIGNED 1/5/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rehoberth Cem,</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockhill S.C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March f/H Inc. 1101 E. North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

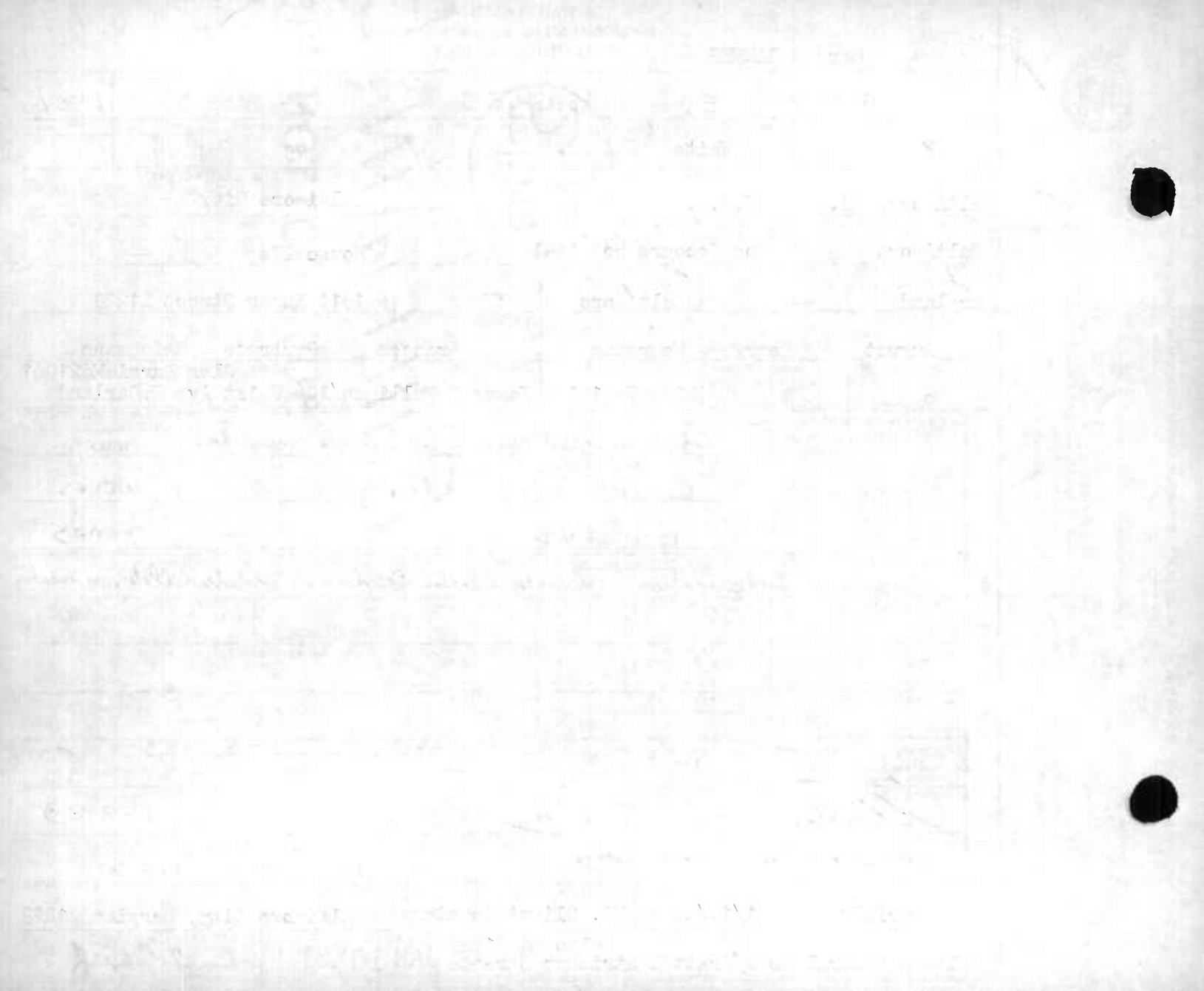
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a photo taken.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Mary E BARNES</b>									
1. DECEASED NAME (TYPE OR PRINT) <b>MARY E. BARNES</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-8-83</b>		2b. HOUR <b>1:35 AM</b>	
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 30 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1311 Kuper Street 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Henry Wehrmann</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Gertrude Reichmans</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-07-9121</b>		17. INFORMANT ADDRESS <b>Glen Burnie Md 21061</b> <b>James R Mulligan/106 W 1st Ave N, Garland</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest probably due to acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HAS CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>WEEKS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Digitalis Intoxication; Probable Lactic Acidosis; Diabetes Mellitus on insulin</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-7-83</b> to <b>1-8-83</b> , that (I) (we) last saw the deceased alive on <b>1-7-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William R. Law MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>1-8-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM R. LAW MD</b>						22e. ADDRESS <b>2000 W. BALTIMORE ST BALTO. MD 21223</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>01/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland 21223</b>			
24. FUNERAL DIRECTOR NAME <b>Walters Funeral Home/Pratt &amp; Stricker Streets</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 00673					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DR. LESLIE B. BARNETT					2a. DATE OF DEATH MONTH DAY YEAR 1 25 1983				2b. HOUR 1:45 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 23 46		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WV. OF MARYLAND HOSP.				12a. NEUROLOGIST (TYPE OF WORK FOR MOST OF WORKING LIFE) XXXXXXXXXX		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STREET ADDRESS 4402 NORWOOD RD.					
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4402 NORWOOD RD.		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BERNKOW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESS MARKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-48-8912		17. INFORMANT ADDRESS DR. BRUCE BARNETT 4402 NORWOOD RD. BALTO., MD 21218						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE UNDIFFERENTIATED LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 4 YEARS										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JAN 25 19 83, to JAN 25 19 83, that (I) (we) lost saw the deceased alive on JAN 25 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE So, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/25/1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) So				22e. ADDRESS 22 S GREENE ST. BALTO. MD. 21201.						
23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL		23b. DATE JAN. 26, 1983		23c. NAME OF CEMETERY OR CREMATORY MORROW CEMETERY		23d. LOCATION MORROW WARREN CO. OHIO				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR FEB 1 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]				

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UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					83 00674 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISAAC BARR					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1983			2b. HOUR 8:23 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 8, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. D 6203 PIMLICO RD. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM LOUIS BARR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA WHITMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-0869		17. INFORMANT ADDRESS STEVEN BARR 311 BOND AVE, REISTERSTOWN, MD. * (21136)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>10/22</i> 19 <i>82</i> to <i>1/12</i> 19 <i>83</i> , that (1) (we) lost <i>10/22</i> 19 <i>82</i> above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph Shear</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SHEAR, M.D.					22e. ADDRESS 6715 PARK HTS. AVE. BALTO., MD 21215				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 14, 1983		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH		23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JAN 18 1983		25b. REGISTRAR'S SIGNATURE <i>J. C. ...</i>	

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				83 00675					
1. DECEASED NAME (TYPE OR PRINT) <u>BARSKY, JOE ALISA</u> <u>BABY BOY</u> LAST <u>BARSKY</u>					2a. DATE OF DEATH MONTH DAY YEAR 1/20/83					2b. HOUR 9:56 AM	
3. SEX MALE <u>♂</u>		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 19, 1983		6. AGE (IN YEARS LAST BIRTHDAY) 1 day YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN 20 15	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Mos P</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3711 GLENGYLE AV. 21215			
14. FATHER'S NAME FIRST MIDDLE LAST CARL BARSKY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELISA GERTEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT CARL BARSKY ADDRESS 3711 GLENGYLE AVE. #21215							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>7689</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>meconium Aspiration at Birth,</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19/83</u> , 19 <u>83</u> , to <u>1/20/83</u> , 19 <u>83</u> , that (we) lost the deceased above on <u>1/20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Janice Prude-Boone MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>1/20/83</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Janice Prude-Boone</u>				22e. ADDRESS <u>600 N. Bond St</u>							
23a. BURIAL, CREMATION OR REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE OF BURIAL, CREMATION OR REMOVAL <u>JAN. 21, 1983</u>		23c. OLD CEMETERY OR PLACE OF BURIAL <u>OLD SHILOH CEMETERY</u>		23d. LOCATION <u>ROSEDALE</u> COUNTY <u>BALTO.</u> MD					
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 26 1983</u>				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			
6010 REISTERSTOWN RD. BALTO., MD 21215											

BP





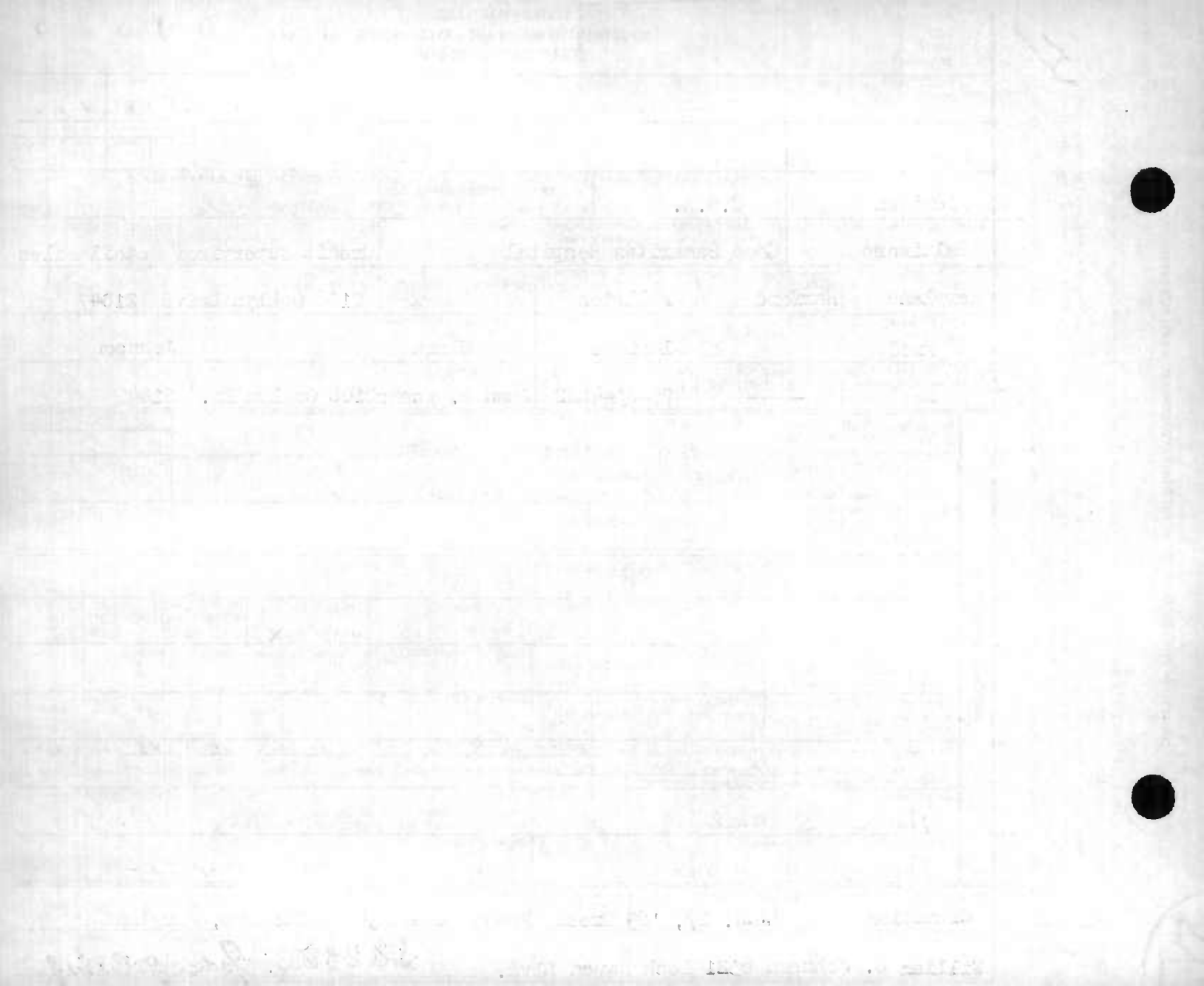
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 6 7 6	
FOR 1 - STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
MAXINE BARTLETT				JANUARY 25, 1983	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		WHITE		MONTH DAY YEAR	
				November 25, 1914	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7a. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Michigan		U.S.A.		68	
		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		Good Samaritan Hospital		Credit Supervisor Retail Sales	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland		Fallston		2108 Oaklyn Drive 21047	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Fred Eldridge		Clara Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		479-05-4822		Jean B. Weeks 2108 Oaklyn Dr. 21047	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
1539 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST					
DUE TO, OR AS A CONSEQUENCE OF					
(b) METASTATIC COLONIC CA.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from DECEMBER 8, 19 83, to JANUARY 25, 19 83, that (he) (we) lost saw the deceased alive on JANUARY 25, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (he) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thomas S. Miller		M.D.		1/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
THOMAS S. MILLER					
22e. ADDRESS		22f. ADDRESS			
		GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Jan. 27, '83		Green Mount Cemetery	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
William E. Johnson		8521 Loch Raven Blvd.		JAN 26 1983	
				25b. REGISTRAR'S SIGNATURE	
				John J. Carls	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JANIS May BATCHELOR</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 5 83</b>			2b. HOUR <b>1:30 A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 47</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 21</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MARYLAND</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 21771</b>					13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond Adler</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Marshall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-44-2679</b>		17. INFORMANT ADDRESS <b>Richard D. Batchelor, Same As #13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2040 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE LYMPHOCYTIC LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTE</b> <b>6 YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC ACTIVE HEPATITIS; GRAM NEGATIVE SEPSIS</b>										
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <b>DEC 27, 19 83</b> , to <b>JAN 5, 19 83</b> , that (we) last saw the deceased alive on <b>JANUARY 5, 19 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (he) (she) (it) (we) view the body after death.										
22b. SIGNATURE <b>Eric J. Tannenbaum, MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/5/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERIC TANNENBAUM MD</b>				22e. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL 22 S. GREENE ST. BALT MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-7-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial</b>		23d. LOCATION CITY OR TOWN <b>Carroll, Md.</b>				
24. FUNERAL DIRECTOR <b>Charles W. Burrier, Jr., Sykesville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>				

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1. The purpose of this study is to determine the effect of the treatment on the response of the subjects. The subjects were divided into two groups, one receiving the treatment and the other receiving a placebo. The results of the study are shown in the following table.

Group	Response
Treatment	100%
Placebo	50%

2. The results of the study show that the treatment has a significant effect on the response of the subjects. The subjects receiving the treatment showed a 100% response, while the subjects receiving the placebo showed a 50% response. This indicates that the treatment is effective in increasing the response of the subjects.

3. The results of the study also show that the treatment has a significant effect on the response of the subjects. The subjects receiving the treatment showed a 100% response, while the subjects receiving the placebo showed a 50% response. This indicates that the treatment is effective in increasing the response of the subjects.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LEON MARGELLUS BATES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 26, 1983</b>		2b. HOUR <b>3:15 A</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 2 11</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHOE REPAIR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HUTZLERS</b>	
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3314 Auchentroly Terrace</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Bates</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Martin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-05-7441</b>	17. INFORMANT ADDRESS <b>L. Olivia Bates-3314 Auchentroly Terr Baltimore, MD 21217</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENO-CARCINOMA COLON WITH METASTASIS TO LIVER</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 25, 19 83</b> , to <b>JANUARY 26, 19 83</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 26, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mukesh Luhar</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MUKESH LUHAR M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/29/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN CEMETERY</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>BALTIMORE CITY, MD</b>	
24. FUNERAL DIRECTOR NAME <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 7 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
GLORIA A. BAUER			01/05/83			3:15pm					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		White		5 7 1950		32 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			THE JOHNS HOPKINS HOSPITAL			Waitress-Edgemere			Moose		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3223 Dundalk Avenue 21222		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. INFORMANT		
Vaughn M. Conrad			Emaline M. Lengrand			No (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			3223 Dundalk Ave. Balto., MD. 21222		
16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
217-52-7068			Emaline M. Conrad			PART 1. DEATH WAS CAUSED BY:					
						IMMEDIATE CAUSE (a) <u>Profound hypotension</u>					
						DUE TO, OR AS A CONSEQUENCE OF					
						(b) <u>Respiratory arrest</u>					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c) <u>Cancer in lungs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>82</u> , to <u>1/5/83</u> , 19 <u>83</u> , that (I) (we) lost											
saw the deceased alive on <u>1/5/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
above (we) (we did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
<u>David A. Foley</u>			MD			1/5/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE		
DAVID A FOLEY MD			Johns Hopkins Hospital, Balt. MD			JAN 7 1983			<u>John J. Carver</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			1/8/1983			Oak Lawn			Baltimore Maryland		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Duda-Ruck, Inc.			JAN 7 1983			<u>John J. Carver</u>					
7922 Wise Avenue Dundalk, MD. 21222											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the entire page 2 and 3 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 20 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO. <b>UM 778 550</b>							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NELLIE JEAN BEARDSSELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 14 83</b>		2b. HOUR <b>8:55 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 3 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MEXICO CITY - Mexico.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED SOCIAL SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2218 ROLAND AVE. ROLAND TOWNSHIP</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George BEARDSSELL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion MEE KNOWL DAVIES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219 50 4037</b>		17. INFORMANT ADDRESS <b>JUDY WALDMAN, 1 PINEY CREEK, MONTICLO</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPTICEMIA &amp; DIVC</b> <b>0384</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DERELICTATED STATE.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>&amp; GI Bleeding &amp; UTI.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2/11/11</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>1-3, 1983</b> , to <b>1-14, 1983</b> , that (b) (we) lost saw the deceased alive on <b>1-14, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Shobha Reddy</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHOBHA REDDY</b>				22e. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/14/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 6 8 1	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLOTTE R. BEATTY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1/25/83</b>			2b. HOUR <b>8:02 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 7 38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Burton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Miller</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT <b>Margie DeVoe</b>		ADDRESS <b>800 Wellington St. Balto. Md. 21211</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4349</b> IMMEDIATE CAUSE (a) <b>Cerebellar Infarct / Tumor</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/21/83</b> , 19__ to <b>1/25/83</b> , 19__ that (I) (we) lost saw the deceased alive on <b>1/25</b> , 19__ <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Kanal Dyal-Dottin</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/25/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. DYAL-DOTTIN</b>			22e. ADDRESS <b>Union Memorial Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>					ADDRESS <b>3818 Roland Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>				
					25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>						



Original

USA

Write

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Housewife

Countryland

Salisbury

822 Howards St. Raleigh, N.C. 27601

Thomas Carson

Mr.

Miller

no

514-22-2407

Marble Device 800 William St. Raleigh, N.C. 27601

Great Lawn Gardens

1/27/73

Barial

A. Alan Bette, Jr. P.O. Box 3119 Raleigh Ave.

Baltimore

Ms.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE P BEAVEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 83</b>		2b. HOUR <b>11:35<sup>P</sup></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 17 1892</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. STREET ADDRESS <b>22 S. Athol Avenue 21229</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James D. Patterson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Hasson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-54-1226</b>	17. INFORMANT <b>Sterrett P. Beaven</b> ADDRESS <b>4053 Pebble Branch Rd. Ellicott City, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5120 IMMEDIATE CAUSE (a) Shock.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumothorax</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Sepsis, Bronchopneumonia, renal failure, Diabetes, Respiratory Failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 13</b> , 19 <b>83</b> , to <b>Jan. 17</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Clement M. Mander</b>			DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-17-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 21, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Port Deposit Cecil Maryland</b>
24. FUNERAL DIRECTOR <b>See. H. Patterson &amp; Son</b>			25. DATE RECEIVED BY BURIAL TRANSIT REGISTRAR <b>JAN 25 1983</b>		

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Tillye Beckenheimer</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-25-1983</i>		
3. SEX <i>FEMALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 19 1906</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>68</i> YRS.		8. IF UNDER 24 HRS. HOURS MIN. <i>10 25</i> A.M.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>XXSA MARYLAND</i>		9b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE</i> CITY MD.		
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Levindale Geriatric Cntr</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		
13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		13e. STREET ADDRESS <i>6950 MARSUE DR., APT. T1</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LENA FREEDBERG</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		
16b. SOCIAL SECURITY NO. <i>4860</i>		17. INFORMANT <i>ALLEN B. SPECTOR</i>		17a. ADDRESS <i>7404 PARK HTS. AVE. BALTO., MD 21208</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>4860</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia and ASCVD</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <i>old Pulmonary Tuberculosis</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. CERTIFY that (I) (this hospital) attended the deceased from <i>9/27</i> 19 <i>76</i> , to <i>1/23</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/23</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <i>N. Haroun</i>		
22c. DATE SIGNED <i>1/23/83</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NAJJI HAROUN</i>		22e. ADDRESS <i>Levindale Geriatric Hosp., Belvedere Greening</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JAN. 24, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PROGRESSIVE BENEFIT &amp; RELIEF ASSOC.</i>		
23d. LOCATION <i>RANDALLSTOWN BALTO. MD</i>		24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; SONS</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 26 1983</i>		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. ADDRESS <i>BALTO., MD 21215</i>		25d. DATE REC'D. BY REGISTRAR <i>JAN 26 1983</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Wilfred</b> MIDDLE <b>H.</b> LAST <b>Bedord</b> <b>WILFRED H. BEDORD</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>17</b> YEAR <b>83</b>		2b. HOUR <b>5:25A</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>SEPT.</b> DAY <b>11</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN - MONTGOMERY WARDS</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>311 OSBORNE AVENUE 21228</b>	
14. FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b></b> LAST <b>BEDORD</b>				15. MOTHER'S MAIDEN NAME FIRST <b>KATHERINE</b> MIDDLE <b></b> LAST <b>WELCH</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17a. SOCIAL SECURITY NO. <b>215-05-3230</b>		17b. INFORMANT ADDRESS <b>1900 Sigel Street 01610 CECILIA MARTIN Worcester, Massachusetts</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE <b>Adenocarcinoma of lung c metastases</b> DUE TO, OR AS A CONSEQUENCE OF: (a) <b>to the mediastinum, @ Arteriosclerotic heart disease c chronic failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b></b> (c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>80</b> , to <b>17 Jan</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>17 Jan</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William J. Bryson</b> M.D.				22c. DATE SIGNED <b>17 Jan 83</b>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Bryson</b> M.D.				22f. ADDRESS <b>St. Agnes Hospital, Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETHANY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MONSON MASSACHUSETTS</b>			
24. FUNERAL DIRECTOR NAME <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES</b>				24b. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>		24c. REGISTRAR'S SIGNATURE <b>John J. Conish</b>			
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228									

MEDICAL CERTIFICATION

29

BP



CARE &amp; MAINT.

Miss Z. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 6 8 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Ella J. Bell				01 11 83	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Black		MONTH DAY YEAR	
				12 31 32	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Virginia		U.S.A.		50 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		3918 Ridgewood Avenue		Baltimore City, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Judge Farrar		Sallie Anderson		13e. STREET ADDRESS	
				3918 Ridgewood Ave. 21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		216 30-0998		John C. Bell	
				3918 Ridgewood Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				10 mos.	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-11-83 to 1-11-83, that (I) (we) last saw the deceased alive on 1-11-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
X Daniel Bakal		MD		1.12.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		1/15/83		Md. Nat. Mem. Pk.	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
NAME ADDRESS		CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE	
Wm. C. March F/H Inc. 1101 E. North Ave.		Laurel Md.		JAN 13 1983	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH L. BELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 20 83</b>		2b. HOUR <b>12<sup>10</sup> pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 13</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Book Binder</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Engraving &amp; Printing</b>		13a. STATE <b>Maryland</b>				
13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Bell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary A. Lanham</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-07-1238</b>		17. INFORMANT ADDRESS <b>Veronica C. Bell 3622 Clarenell Road 21229</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4349</b> IMMEDIATE CAUSE (a) <b>Multiple infarction of brain</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Aortic Stenosis, Probable Aspiration pneumonia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> , 19 <b>83</b> , to <b>Jan 20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Carlos Gouantes</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>JAN 20, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARLOS GOUANES</b>		22e. ADDRESS <b>900 Caton Avenue</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/24/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>				
25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Carver</b>				

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





RECEIVED  
JAN 28 1964

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 8 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn Anna Belt</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 2, 1983</i>			2b. HOUR <i>12:19 A.M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 29 27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>-----</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2919 Hudson Street 21224</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bernard H Hess</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edmurg</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-22-9408</i>		17. INFORMANT ADDRESS <i>Richard F. Belt 2919 Hudson Street 21224</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Cor pulmonale, Poss. A.M.I.</i> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>81</i> , to <i>1/2</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>1/12/83</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert Liberto, MD.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/3/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT LIBERTO</i>					22e. ADDRESS <i>3508 BANK ST 21224</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-6-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore A.A. Co., Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>C.S. Zeiler &amp; Son Inc. 901 S. Conkling Street</i>					25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) <i>JAN 4 1983 Joan Z. Gainer</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 6 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RONALD BELT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 31, 1983</b>			2b. HOUR <b>9:17 P</b>	
3. SEX <b>MALE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 45</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2403 Sherwood Ave, 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Belt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roxann Freeman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-48-1412</b>		17. INFORMANT ADDRESS <b>Martha Winston 106 Honeysuckle St.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4254

IMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cardiomyopathy**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Alcohol Abuse**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> , 19 <u>83</u> , to <u>1/31</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>R. Michael Wyman</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/31/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. MICHAEL WYMAN</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/4/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md</b>
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



JACKSONVILLE, FLORIDA

TELEPHONE

4-4-4

4-4-4

12/15

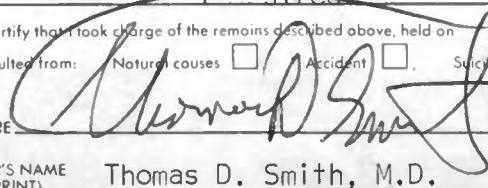
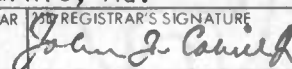
12/15



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 83 00689	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>LEONARD BENJAMIN</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 9 19 83</b>		2b. HOUR <b>10:10</b>		
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 21 42</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		7c. DATE PRONOUNCED DEAD <b>1 9 19 83</b>		2d. HOUR <b>10:10</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. <b>sep.</b> <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>2452 Joseph Ave. 21225</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Benjamin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Catherine Benjamin 2452 Joseph Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of abdomen (unspecified weapon)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>8:10 P.M. 1-9- 19 83</b>				21b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR <b>8:10 P.M. 1-9- 19 83</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject was shot.</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2400 blk. Joseph Ave., Balto. City Md.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1-10-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/14/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 Liberty Hgts. Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1983</b>		25b. REGISTRAR'S SIGNATURE 			

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT



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BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

1975



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00690			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1 21 83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET O. BENNETT				2b. HOUR 3 40 P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 6 15		6. AGE (IN YEARS LAST BIRTHDAY) 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ports		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 151 Northdale Road 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-28-8685		17. INFORMANT Dorothea A. Doyle		ADDRESS 529 Brisbane Road 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC 17 19 82, to JAN 21 19 83, that (I) (we) lost <u>saw</u> the deceased alive on JAN 21 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter H Cooke, MD				DEGREE MD		22c. DATE SIGNED 1/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter H Cooke				22e. ADDRESS 3001 S. Hanover St, Bk 1to			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY A.A. Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR JAN 24 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

MEDICAL CERTIFICATION



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1962" and "MAY 1962" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00691			
1. DECEASED NAME (TYPE OR PRINT) <b>Samuel Bennett</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 22, 1983</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 20, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Dentsville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Dentsville, Maryland 20646</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Bennett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Dorsey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-12-3550</b>		17. INFORMANT ADDRESS <b>Margaret Day Baltimore, Maryland 21217</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1519</b> IMMEDIATE CAUSE (a) <b>Metastatic Gastric Adeno Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Associated Condition Prostatic Hyperplasia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 19, 1982</b> to <b>January 22, 1983</b> , that (I) (we) last saw the deceased alive on <b>January 22, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Tommy T. Hsu M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TOMMY T. HSU M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Church</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Newport Charles MD</b>	
24. FUNERAL DIRECTOR NAME <b>Thornton's Funeral Home Pomomkey, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

83 00692

 FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Melvin W Benton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 08 83</b>		2b. HOUR <b>9 45 PM</b>
3. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 20 16</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Longshoreman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>John E. Clark Co</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY -----	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Warren ----- Benton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy ----- Twigg</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.H. 2 214-01-9501</b>		17. INFORMANT ADDRESS <b>Mrs. Hazel B. Benton, Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible myocardial infarction</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCVD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/8</b> , 19 <b>83</b> , to <b>1/8</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jorge Vallecillo, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jorge Vallecillo</b>		22e. ADDRESS <b>536H</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE, IF Y) <b>Burial</b>		23b. DATE <b>Jan. 13, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home, 130 E. Fort Ave. Balto., Md. 21230</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		JAN 11 1983	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00693			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA BENZION				2a. DATE OF DEATH MONTH DAY YEAR FRI. JAN. 28, 1983			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 7, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6810 PARK HEIGHTS AVE., APT. 100		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC SAMUEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT MR. DAVID LEVIN 6810 PARK HEIGHTS AVE., APT. 100 #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4100</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>83</u> , to <u>1-28</u> , 19 <u>83</u> , tho (I) (we) lost saw the deceased alive on <u>1/20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>BR Mocher, MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-28-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard R Shochet, MD				22e. ADDRESS 6804 Park Heights Ave 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-30-83		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH BETH ISRAEL CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR FEB 1 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA FPMR (41 CFR) 101-11.6



RECEIVED  
JAN 11 1963  
OFFICE OF THE  
DIRECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

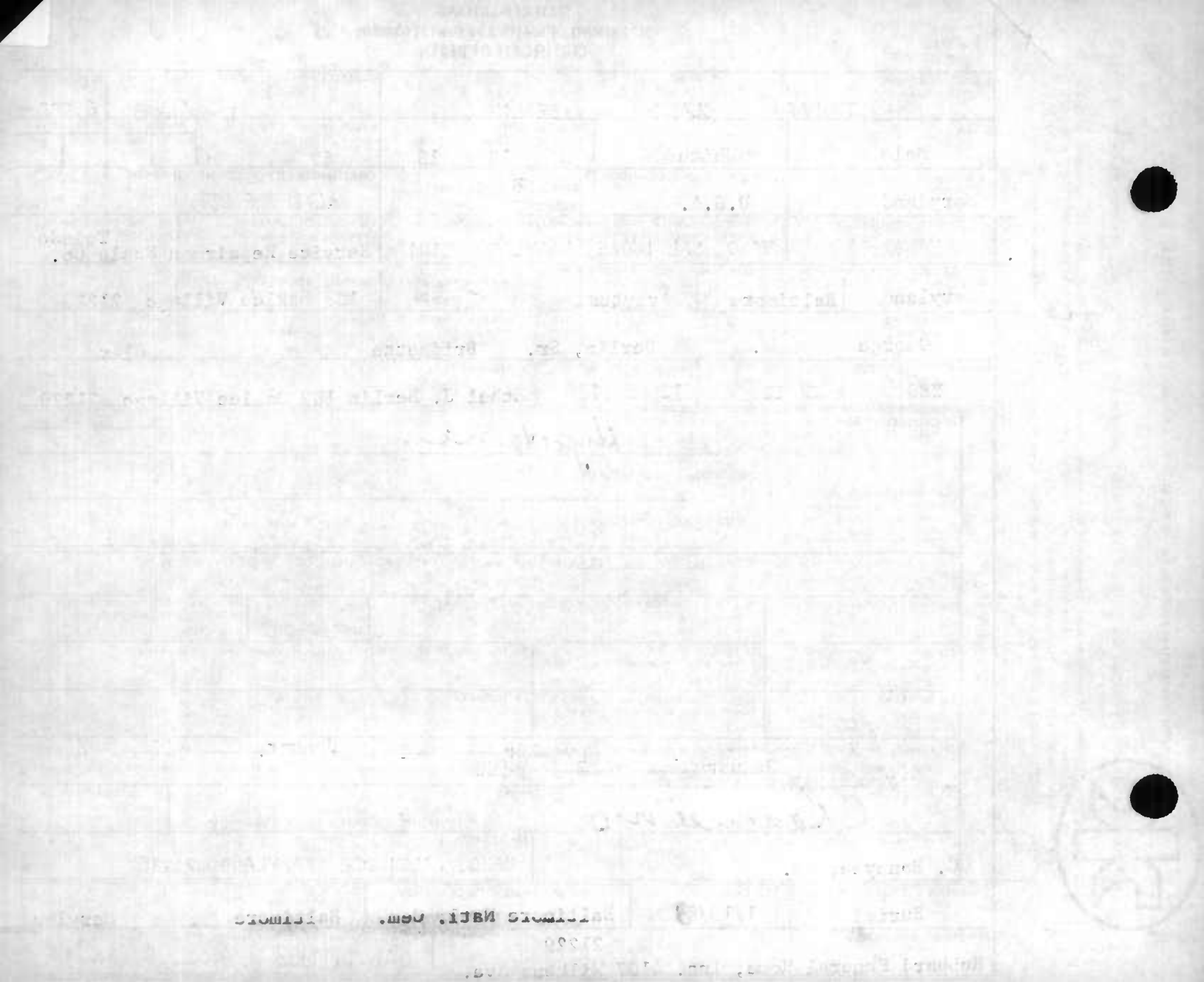
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IMPORTANT: If item 21 is marked of, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00694			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THOMAS CLARK BERLIN</b>				MONTH DAY YEAR <b>1 6 83</b>		2b. HOUR <b>6:50P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Repairman Scale Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Toledo</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Berlin, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridgette Clark</b>		17. INFORMANT ADDRESS <b>Ethel J. Berlin 189 Oaklee Village 21229</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 212 05 2133</b>		17. INFORMANT ADDRESS <b>Ethel J. Berlin 189 Oaklee Village 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1550</b> IMMEDIATE CAUSE (a) <b>Aneurysm.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 20</b> , 19 <b>82</b> , to <b>January 6</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 6</b> , 19 <b>83</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <b>C. Baneyee MD.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. Baneyee, MD.</b>				22e. ADDRESS <b>VAMC, BALTIMORE, MARYLAND 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/10/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Natl. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Grier</b>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 00695	
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT) <b>Carl G. Betz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-28-83</b>		2b. HOUR <b>8:30 A.M.</b>						
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 26, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7 UNDER 24 HRS HOURS MIN <b>0 0</b>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		9a CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9b MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
11 CITY OR TOWN OF DEATH <b>Baltimore</b>		12a NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>404 N. Haven Street</b>				12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>		12c KIND OF BUSINESS OR INDUSTRY <b>Esskay Meats</b>			
13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <b>Md.</b>		13b COUNTY <b>---</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>21224 404 N. Haven Street</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Betz</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret ?</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO. <b>---</b>		17 INFORMANT <b>Baltimore, Md. 21224.</b> <b>Mrs. Lorraine O. Betz-404 N. Haven St.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 mo</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>A3 CVD</b>											
19a DATE OF OPERATION <b>1-26-83</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>A3 CVD</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>1-26-83</b> to <b>1-28-83</b> , that (I) (we) lost saw the deceased alive on <b>1-26-83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b SIGNATURE <b>Dr. Wyman Wong</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>1-28-83</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wyman Wong</b>				22e ADDRESS <b>6730 Holabird ave Balto, md 21222</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1/31/83</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery-Baltimore, Md.</b>				23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME <b>John A. Morris Inc.</b> <b>2000 E. Baltimore St. Baltimore, Md. 21224</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 31 1983</b>				25b REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



Card

Serial

White

Spec. 20, 1942

X

Baltimore

ADM. B. Wilson

Ad.

Baltimore

X

1934

ADM. B. Wilson

Group

Spec.

1934

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Baltimore

ADM. B. Wilson

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Y

1-1-42

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Group

1-1-42

ADM. B. Wilson

1-1-42

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17  
(VR A15 ME (5))  
20M 4/82

Item 2a Film 576 2-10-83										STATE OF MARYLAND									
FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 00696									
1. DECEASED NAME (TYPE OR PRINT) <b>WARREN BEVERLY, SR.</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 MONTH 28 DAY 83 MATED <input type="checkbox"/> 1-29-83 19									
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 29 10</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>72 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>1-29-83 19</b>		2b. HOUR <b>1:35</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>299 S. Spring Ct.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>299 S. Spring Ct. 21231</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nathaniel Beverly</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Gross</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>213-09-5194</b>					17. INFORMANT ADDRESS <b>Ruth Jones 932 N. Washington St.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Margarita A. Koroll</i>					TITLE (SPECIFY) <b>Assistant</b>					DATE SIGNED <b>1-30-83</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b>					ADDRESS <b>111 Penn Street</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>2/4/83</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cem</b>									
23d. LOCATION CITY OR TOWN <b>Baltimore</b>					COUNTY <b>Co.</b>					STATE <b>Md.</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>					25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>				

ON FRIDAY, 25-1-1945, THE 1st AIRBORNE DIVISION  
CAME TO THE AIRPORT AND THE 1st AIRBORNE DIVISION  
WENT TO THE AIRPORT AND THE 1st AIRBORNE DIVISION





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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00697			
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS BIALIK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 21, 1983</b> 2b. HOUR A <b>0630 M</b>			
3. SEX <b>M</b> MALE		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 22 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland</b>		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postman</b>		13. KIND OF BUSINESS OR INDUSTRY <b>U.S. POSTAL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hyman BIALIK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Yetta KIRSHENBAUM</b>		16. SOCIAL SECURITY NO. <b>064-36-7667</b>		17. INFORMANT <b>KIRSHENBAUM BROS.</b>	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		18b. SOCIAL SECURITY NO. <b>064-36-7667</b>		18c. ADDRESS <b>1153 CONEY IS. AVE. BROOKLYN, NY 11230</b>		18d. ADDRESS <b>1153 CONEY IS. AVE. BROOKLYN, NY 11230</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1919 IMMEDIATE CAUSE (a) Ventricular Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis, pulmonary embolism</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>years</b> <b>several days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Glioblastoma</b>							
19a. DATE OF OPERATION <b>1/7/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Glioblastoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <b>1/21/83</b>		21h. SIGNATURE <b>Daniel Schwartz MD</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> , 19 <b>82</b> , to <b>1/21</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)				22b. ADDRESS <b>2005 Fitzwarrin Pl #101 Balt MD 21209</b>		22c. DATE SIGNED <b>1/21/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Schwartz MD</b>		22e. ADDRESS <b>2005 Fitzwarrin Pl #101 Balt MD 21209</b>		22f. DATE SIGNED <b>1/21/83</b>		22g. SIGNATURE <b>John J. Connel</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>		23b. DATE <b>JAN 23, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WELLWOOD L.I. NY</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALT., MD 21215</b>				25a. DATE REC'D BY REGISTRAR <b>JAN 26 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 18. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 0 0 6 9 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS BILLER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 13 19 83	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 82 YRS.		7c. DATE PRONOUNCED DEAD 1 13 19 83		2b. HOUR 9:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEALER			
12b. KIND OF BUSINESS OR INDUSTRY USED TRUCKS				13a. STREET ADDRESS APT. 618 #21215				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 2500 W. BELVEDERE AVE.			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BILLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST YETTA FORMAN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 217-32-8006A				17. INFORMANT ADDRESS CHESTER, MD. 21619				17. INFORMANT MR. RONALD BILLER 341 E. ROUTE 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 Cranio-cerebral trauma (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Myocardial infarct										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1-3- 19 83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject collapsed on street.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21i. LOCATION STREET CITY OR TOWN COUNTY STATE 6400 blk. Reisterstown Rd., Balto. City Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-14-83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/16/83		23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL				23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25a. DATE REC'D. BY REGISTRAR JAN 18 1983				25b. REGISTRAR'S SIGNATURE J. J. Connel			
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215											



OFFICE OF THE  
SOLICITOR GENERAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 000699	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE E. BISHOP 111</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-25-83</b>		2b. HOUR <b>10:48</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>12</b> YEAR <b>60</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>22</b> YRS.	7. IF UNDER 1 YR. MONTHS <b>22</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	8. IF UNDER 24 HRS. MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	2c. DATE PRONOUNCED DEAD <b>1-25-83</b>		2d. HOUR <b>10:48</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>S.T.U. University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Armed Forces</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>568 Presstman St. 21217</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>E.</b> LAST <b>Bishop Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Jessie</b> MIDDLE <b>Flowers</b> LAST <b>Flowers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>79-82</b>		17. INFORMANT <b>Jessie Bishop</b>		ADDRESS <b>568 Presstman St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>8PM</b> A.M. <b>1-25-83</b> YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, BARN, ETC.) <b>street</b>		21f. LOCATION <b>1600blk Pennsylvania Ave. Balto., Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margie One Kell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1-26-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-31-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Anne Arundel Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Carlton C. Douglass</b> ADDRESS <b>1012 Pennsylvania</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00700

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST MIDDLE LAST JAMES Vincent BITTNER			MONTH DAY YEAR 1 31 83			728 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male ♂		White		MONTH DAY YEAR 7 19 27		55 YRS.		MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MO		USA				Balto. CITY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
MO		S. BALTO GEN'L HOSP.				MECHANIC		Chevron USA		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MO			Anne Arundel		BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5700 PHILLIPS ST. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
STANLEY Bittner					JOSEPHINE Babonek					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
no			216-20-6364		Anna E. Bittner			Same as #13		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3481 IMMEDIATE CAUSE (a) <u>Myocardial Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>anoxic encephalopathy 51P CPR</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> , 19 <u>83</u> , to <u>1/31/83</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>1/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Karen Newton</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/31/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAREN NEWTON</u>			22e. ADDRESS <u>S. Balto. Gen'l Hosp. Balto. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>2/4/1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, A. A. Co., Md.</u>			
24. FUNERAL DIRECTOR NAME <u>McCurly Funeral Homes</u>			24b. ADDRESS <u>Baltimore, Md., 21225</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 2 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNIE L. BLAINE			2a. DATE OF DEATH MONTH DAY YEAR 1/15/83			2b. HOUR 4:30 A.M.		
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 04 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CAROLINA MAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLA MOSS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218463489		17. INFORMANT ADDRESS M. FERGUSON MD. BALTO CITY HOSP.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>RESPIRATORY FAILURE. METABOLIC ACIDOSIS</u>								
19a. DATE OF OPERATION <u>1/19/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>none</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>none</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>none</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>none</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>none</u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19/83</u> , 19 <u>83</u> , to <u>1/15/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1/15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Mark S. Ferguson MD Intern</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/15/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARK S. FERGUSON MD</u>				22e. ADDRESS <u>BALTO CITY HOSPITAL</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/19/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm C March F/H 1101 E. North Ave</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>		

MEDICAL CERTIFICATION

9  
9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Items #10a-22a Film G575 1/31/83 r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00702

1. DECEASED NAME (TYPE OR PRINT) <b>William Randall "Randy" Blair</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 8 19 83</b>			2b. HOUR M <b>9:09</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16, 1950</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>32 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 8 19 83</b>	2d. HOUR P M <b>9:09</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sportscaster</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William O Blair</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alberta E Edlund</b>		16. SOCIAL SECURITY NO. <b>213 56 6927</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213 56 6927</b>		17. INFORMANT ADDRESS <b>Mrs Marjorie Blair 3354 N Chatham Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4254 IMMEDIATE CAUSE (a) Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <b>H R Guard</b>		TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>1/10/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Harry H. Witzke</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



RECEIVED  
JAN 10 1953

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U.S.A.

Washington D.C.

Television

Spencer

X 3354 N. CHASEMAN ROAD 3354

ELIZABETH CITY

Maryland Howard

Algebra H. R. R. R.

William O. Black

Mrs. MARGARET BLACK 3354 N. CHASEMAN ROAD

213 35 6827

Howard, Maryland

JAN. 12, 1953

RECEIVED

RECEIVED JAN 12 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00703

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>Blake Agnes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-15-83</b>			2b. HOUR <b>2:05 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 19 63</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Fottit</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ina Allan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-09-5996</b>		17. INFORMANT ADDRESS <b>Mr. Joseph Blake 245 W. 31st St. Balto., Md.</b>			

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

1889 IMMEDIATE CAUSE (a) **METASTATIC CA BLADDER**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **UREMIA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mary Carroll</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY CARROLL</b>				22e. ADDRESS <b>301 ST. PAUL ST. BALTO. MD. 21202</b>			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Carroll</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the funeral home to prepare the body for burial or cremation. The funeral home must be notified within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or retention.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 3 0 0 7 0 4

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE C. BLAKE			2a. DATE OF DEATH MONTH DAY YEAR 01 31 83			2b. HOUR 11:50 <sup>A</sup>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-31-1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3214 Belair Rd. - 21213	
14. FATHER'S NAME FIRST MIDDLE LAST John Philip Reuther				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Doering					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218-10-17680 220-24-5345		17. INFORMANT ADDRESS Mr. Charles E. Blake - 3214 Belair Rd. - 21213			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Severe congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from 1/21, 1983, to 1/31, 1983, that (ii) (we) last saw the deceased alive on 1/31, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.							
22b. SIGNATURE Robert A. Miller				DEGREE MD		22c. DATE SIGNED 1/31/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT A. MILLER, M.D.				22e. ADDRESS 201 E. University Pkwy. Balto. Md. 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-3-83		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc. - 6415 Belair Rd. - 21206				25a. DATE REC'D. BY REGISTRAR FEB 3 1983		25b. REGISTRAR'S SIGNATURE John J. Conish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 7 0 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William S. Blanton						2a. DATE OF DEATH MONTH DAY YEAR January 8, 1983			2b. HOUR 4:55 pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 6 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Engineer			12b. KIND OF BUSINESS OR INDUSTRY Local 37		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2326 Old Frederick Road 21228			
14. FATHER'S NAME FIRST MIDDLE LAST William Harold Blanton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 225-16-6548		17. INFORMANT Mildred Blanton				ADDRESS 2326 Old Frederick Rd. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4414 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abdominal aortic aneurysm rupture</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIC due to massive transfusion</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION 1/7/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED shock				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/7 1983, to 1/8 1983, that (I) (we) lost saw the deceased alive on 1/8 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. S. Lin</i>				DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Lin				22e. ADDRESS 900 S. Caton Avenue Baltimore, Md. 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR JAN 10 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

10

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows in several paragraphs]

CHIEF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 1650M / B1  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00706

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ENNIS</b>			2a. DATE OF DEATH MONTH <b>JANUARY</b> DAY <b>22</b> YEAR <b>1983</b>			2b. HOUR <b>9:54</b> A M				
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>7</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2568 Salerno Pl 21230</b>	
14. FATHER'S NAME FIRST <b>CHARLIE</b> MIDDLE LAST <b>BLOODSAW</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE LAST <b>WEBB</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Willie Bloodsaw 3531 Old Frederick Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MALIGNANT PERICARDIAL EFFUSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SQUAMOUS CELL CARCINOMA OF THE LUNG</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James T. Heisler M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/23/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James T. Heisler M.D.</b>			22e. ADDRESS <b>3001 S. Hanover St, Baltimore, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc.</b> ADDRESS <b>1101 E. North Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 0 7 0 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

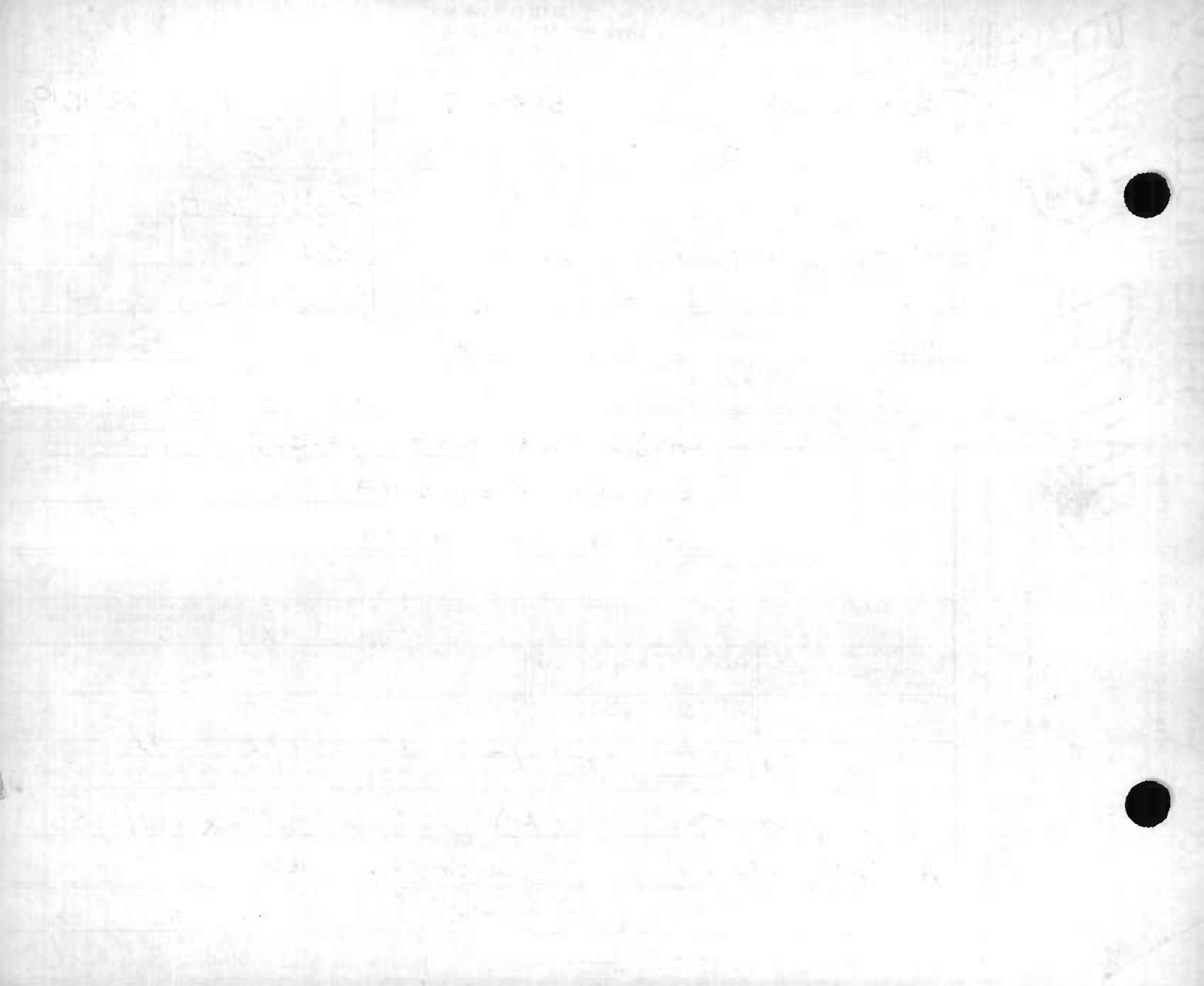
1. DECEASED NAME (TYPE OR PRINT) <b>Augustus</b>		FIRST <b>BLOUNT</b>		LAST <b>BLOUNT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/2/83</b>		2b. HOUR <b>10<sup>10</sup> PM</b>	
3 SEX <b>M</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 25 12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Farmville, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balti - City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp of Md.</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Ret</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1635 Poplar Grove St.</b> 21216	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Will</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clydie Vines</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>239-01-6781</b>		17 INFORMANT ADDRESS <b>Alice Blount 1635 Popular Grove St.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>5990</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BILATERAL PNEUMONIA</b> (c) <b>URINARY TRACT INFECTION</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY. HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> 19 <b>83</b> to <b>1/2</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/2</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. Osei-Nusu</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. OSEI-NUSU</b>				22e. ADDRESS <b>LUTHERAN HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. north Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b> REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



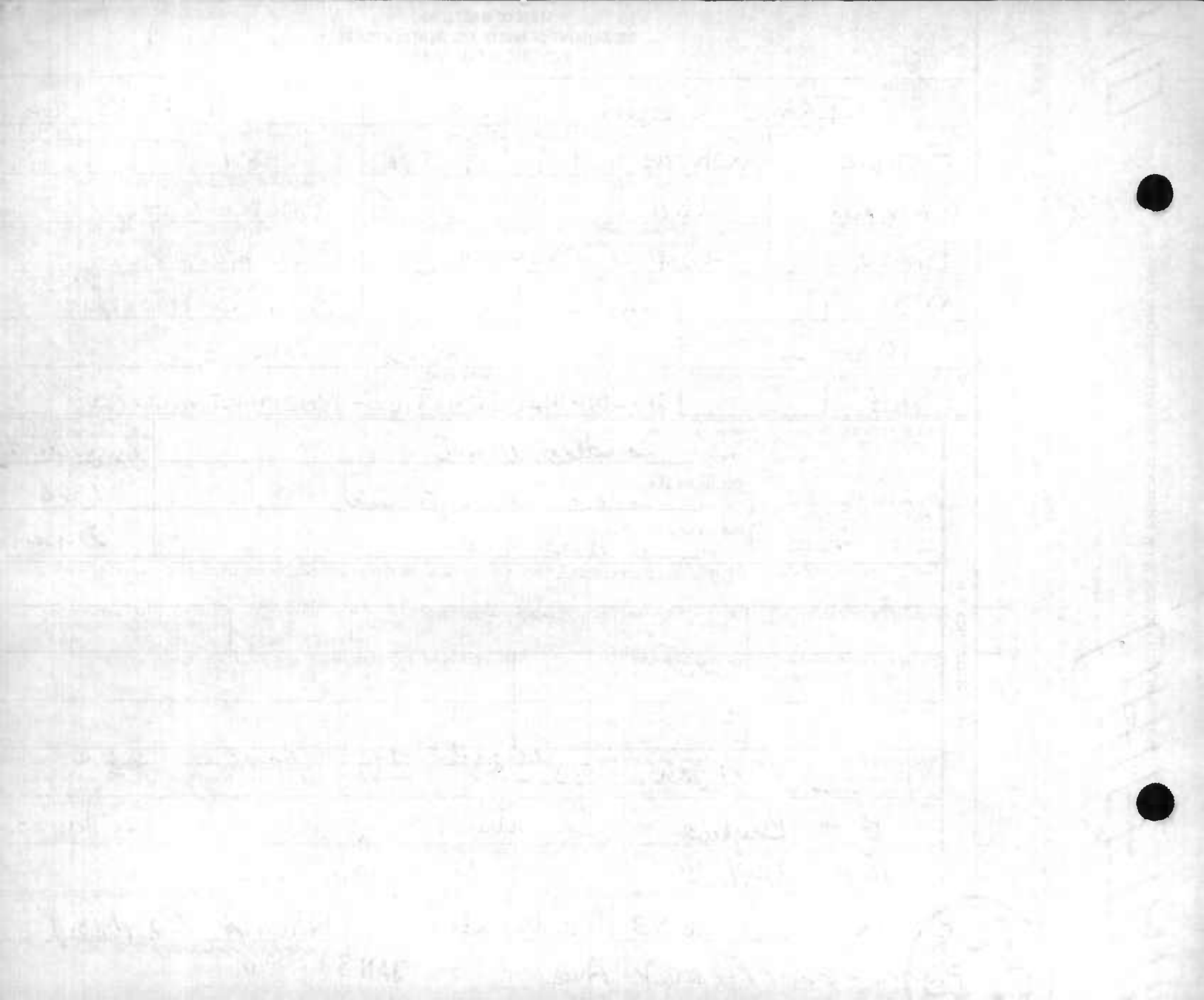


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>IRma Cecelia Bock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 23 83</b>		2b. HOUR <b>2 A M</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 19 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>304 S. Monroe</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STENOGRAPHER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>304 S. Monroe</b> <b>21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MARTIN Bock</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Marie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-01-4027</b>		17. INFORMANT ADDRESS <b>Irma Tice - 1802 MALTRAUERS Rd 21061</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>H.A.C. V.D.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>20 yrs</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>79</b> , to <b>Jan</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>17 Jan</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>H. H. Bayliss</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>25 Jan 83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. H. BAYLISS</b>		22e. ADDRESS <b>1600 WILKENS AVE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowdale</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harvard Co Md</b>
24. FUNERAL DIRECTOR NAME <b>FARLEY - 6601 Frederick Ave</b>				25a. DATE REC'D. BY HEALTH TRANSFER AGENT'S SIGNATURE <b>JAN 31 1983</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 7 0 9					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Catherine					Bogdan					January 29 1983				M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		White		Oct. 4 1903			79 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore		U.S.A.						Baltimore City MD.							
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore				2408 E. Fayette St. 21224				Housewife							
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2408 E. Fayette St. 21224				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Joseph - Godek					Marianna - Manczak										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
no					216-09-9801			Leon J. Bogdan 327 Imla St. 21224							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent aortic valve replacement</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1980</u> to <u>Present</u> , that (I) (we) lost saw the deceased alive on <u>12/8</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Norberto M. Machiran</u>										DEGREE		22c. DATE SIGNED 1/31/83			
22d. PHYSICIAN'S SIGNATURE (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
NORBERTO M. MACHIRAN, M.D.										4713 LEEDS AVE. BALTO., MD 21227					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Febr. 2, 1983		Gardens of Faith Cem.				- - Baltimore Co., Md.					
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lilly & Zeiler Inc. 1901 Eastern Ave. (21231)										FEB 1 1983		<u>John S. Smith</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>SEBASTIEN BOLAND</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5, 1983</b>			2b. HOUR <b>10:20 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 4, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>YRS. 1</b>		IF UNDER 1 YEAR MONTHS DAYS <b>1</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18 Torlina Court 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Boland</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine d'Arcanges</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert Boland</b>		ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>7469</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Congenital Heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10hrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>None</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1983</b> , to <b>Jan 5, 1983</b> , that (I) (we) last saw the deceased alive on <b>JAN 5, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Steven R. Cohen MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-5-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven R. Cohen</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 8, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>				24b. ADDRESS <b>6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <b>JAN 17 1983</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 00711				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY DOLORES BOLESTA					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 1 21 83 5:25 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 10 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cust. Relations		12b. KIND OF BUSINESS OR INDUSTRY Stewart's	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1224 Ten Oaks Road 21227			
14. FATHER'S NAME FIRST MIDDLE LAST William Plate		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Pole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-10-4144		17. INFORMANT ADDRESS Joseph R. Bolesta, Jr. 724 Glen Dr. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1569 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma of biliary system</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardio-cutaneous fistula and Pancreatitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 1/20		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/20, 1982, to 1/21, 1983, that (I) (we) lost saw the deceased alive on 1/21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Sow-Set Lin				DEGREE		22c. DATE SIGNED 1/21/83		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SOW-SET LIN				22f. ADDRESS 900 Caton Avenue					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR JAN 24 1983		25b. REGISTRAR'S SIGNATURE James J. Conner			



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Handwritten signature or text at the bottom left.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 7 1 2			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Emma R. Boller</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01 24 83</b> 2b. HOUR <b>10:30 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 10 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carver Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemp.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto., Md</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS <b>3910 Dolfield Ave. 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-32-4210</b>		17. INFORMANT ADDRESS <b>Lanue Clark, Jr. 3910 Dolfield Ave. 21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GANGRENE RIGHT FOOT-LEG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LEFT CVA AND HEMIPLEGIA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>LEFT CVA AND HEMIPLEGIA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-02</b> 19 <b>82</b> , to <b>01-24</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>01-21</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE <b>Richard Tyson, MD</b> DEGREE				22c. DATE SIGNED <b>01-24-83</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD TYSON, MD.</b>				22f. ADDRESS <b>936 W. NORTH AV. BALTIMORE MD 21217</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT</b> 4600 Liberty Hgts. Ave.				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

OFFICE OF THE  
DIRECTOR

Division of  
Entomology

Section of  
Plant Diseases

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SUE			2a. DATE OF DEATH MONTH DAY YEAR 01-10-83			2b. HOUR 9:40pm		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 30 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Own Home		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Vincint Scaglione			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise D'Amico			16. ADDRESS 3428 Yorkway Balto., MD. 21222		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-6362		17. INFORMANT Linda S. Mattern			ADDRESS 3428 Yorkway Balto., MD. 21222
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-06-</u> 19 <u>83</u> , to <u>01-10-</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>01-10-</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <u>A. P. Nazemi M.D.</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/10/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A.F. NAZEMI M.D.					22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/14/1983		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222					25. DATE REC'D BY REGISTRAR JAN 13 1983			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 77 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00714			
1. FOR STATE REGISTRAR				7a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alma V. Bonnevillle				7b. DATE OF DEATH MONTH DAY YEAR 1/13/83 2:40 PM			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2/14/06		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (IF EMPLOYED, GIVE NAME OF WORKING INDUSTRY) XXXXXXXXXXXXXXXXXX		12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 35 Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM TILDEN HURLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE VERDONIA WILLEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Unknown		16b. SOCIAL SECURITY NO. 219-07-7924	
17. INFORMANT daughter		ADDRESS Md. 21225		Mrs. Elsie J. Adams, 12 Walton Ave., Balto.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5324 Cardio-pulmonar arrest				DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Persistant Hypotension from Septic Shock				DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Bleeding duodenal peptic ulcer disease & Renal Failure							
19a. DATE OF OPERATION 1/5/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute bleeding duodenal ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) I (we) hospital attended the deceased from Jan. 1, 19 83, to Jan. 13, 19 83, that (1) I (we) last saw the deceased alive on Jan. 13, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.				22b. SIGNATURE Lawrence R. Bell # DEGREE		22c. DATE SIGNED 1/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence R. Bell #		22e. ADDRESS 3001 S. Hanover St., Baltimore, Md.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Jan. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.	
24. FUNERAL DIRECTOR Curran Funeral Home, 308 High St. 21613		24b. ADDRESS Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR JAN 17 1983		25b. REGISTRAR'S SIGNATURE John J. Lamer	

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ALLISON TIDWELL HUNTER  
VERDONIA HUNTER  
N. T. HUNTER, 12 Wilson Ave.,  
119-07-7914

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH				MONTH		DAY		YEAR		2b. HOUR					
Irene						Boone		XX				1		15		1983		M					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				MONTH		DAY		YEAR		2d. HOUR			
Female	Col 2	1 12 35 47		47 YRS.						1				15		1983		1:30A		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA						WIDOWED		DIVORCED		Baltimore City,		MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital						Housewife															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Md.				Balto.		YES X NO		2257 Carlton St		21223													
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST									
Clarence						upshire		Ethel						Matthews									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
(YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		218-30-6827		Sheryl Parker		2257 Carlton St															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																							
5770 IMMEDIATE CAUSE (a) Pancreatitis																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b)																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES NO XX							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
21d. INJURY OCCURRED WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE			
NOT WHILE AT WORK								STREET															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED									
Thomas D. Smith				M.D. Deputy Chief										1/15/83									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY				STATE			
Burial				1-19/83				Mt. Auburn Cerm.				Balto.				Md.							
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Charles H. Powell				1-31-83				Schroeder				JAN 19 1983				John J. Schuch							



UNOFFICIAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00716			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Boone</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 13, 1983</b>			
3. SEX <b>Male</b>				4. RACE <b>Black</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 15</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>			
13c. CITY OR TOWN <b>Balto.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>404 Pit, am Place 21202</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Garfield Boone</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Taylor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-01-1128</b>			
17. INFORMANT <b>Helen Boone</b>				ADDRESS <b>404 Pitman Pl.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5325 IMMEDIATE CAUSE (a) Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Respiratory Arrest</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>January 6, 1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated post duodenal ulcer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 6, 1983</b> , to <b>January 13, 1983</b> , that (I/we) last saw the deceased alive on <b>January 13, 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) did (did not) view the body after death.							
22b. SIGNATURE <b>Handwritten Signature</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-14-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jetti K. Prasad, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/18/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

BP 8



International Convention, London 1908

International Convention, London 1908

International Convention, London 1908

International Convention, London 1908

International Convention, London 1908

International Convention, London 1908

International Convention, London 1908

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 1 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LUCY B. BORMUTH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 26 83</b>		2b. HOUR <b>7:10 PM</b>	
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>clothing</b>	
13a. STATE <b>MD-21206</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. STREET ADDRESS <b>4504 LA SALLE AVE-</b> 21206	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Birner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TERESA Stengle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-40-2658A</b>		17. INFORMANT ADDRESS <b>S. Dhillon MD GOOD SAMARITAN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES A.S.C.V.D., HYPERTENSION</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-23-83</b> , 19____, to <b>1-26-83</b> , 19____, that (I) (we) lost saw the deceased alive on <b>1-26-83 6:00 PM</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. P. Dhillon MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-26-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. P. Dhillon</b>				22e. ADDRESS <b>Good Samaritan hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. G. Smith</b>			

BP

04-15



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical director must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00718

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1 19 83		11 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		08 1899		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA		BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		LEVINDALE HEBREW HOME		NURSE (SUPERVISOR) MEDICAL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
						APT. 203	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
MAYER		FRANCES		NO		216-32-6195	
		KORB		17. INFORMANT		MR. HERMAN ROSENBERG	
				3510 ANTON FARMS RD. BALTO., MD		21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							1-82
IMMEDIATE CAUSE (a) CA Lung with							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Cerebral metastases							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
CA CIRCUMSTANCES OF MALIGNANCY							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-15-82, to 1-19-83, that (I) (we) lost saw the deceased alive on 1-19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
[Signature]				1-20-83		B. ZAW-WIN, MD	
22e. ADDRESS				22f. DATE REC'D. BY REGISTRAR			
Levinvale Geriatric 21215				JAN 26 1983			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		JAN. 21, 1983		HAR ZION TIFERETH ISRAEL		ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
SOL LEVINSON & BROS., INC.				25b. REGISTRAR'S SIGNATURE			
6010 REISTERSTOWN RD. BALTO., MD 21215				[Signature]			

MEDICAL CERTIFICATION

911 88 91 1

5-109

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CHIEF

20% COL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Craig S. Boston			2a. DATE KNOWN OF DEATH 1 16 1983			2b. HOUR 2:35A		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH DEC. 17 1961	6. AGE (IN YEARS) 21 YRS.	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 1 16 1983			2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 413 Charter Oak Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MO.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Rolano W. Boston, JR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie K. UPDEGRAFF		13e. STREET ADDRESS 21234 13034 HARFORD ROAD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 84 2071		17. INFORMANT FAMILY RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Shotgun wound of head DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:12 PM 1 16 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 413 Charter Oak Ave, Baltimore City, Md.				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . and in my opinion								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) Deputy Chief, MEDICAL EXAMINER					DATE SIGNED 1/16/83	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Jan. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL		ADDRESS 18800 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR JAN 18 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

(2)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Baltimore Health Department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 0 7 2 0			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie E. Boston						2a. DATE OF DEATH MONTH DAY YEAR 1 21 83				2b. HOUR 4:02 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 05 98		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3223 YOSEMITE AVE 21215					
14. FATHER'S NAME FIRST MIDDLE LAST JAMES HENSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA BOOTH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-24-2624		17. INFORMANT ADDRESS Lawrence Boston 3223 Yosemite Ave									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Recurrent + Metastatic Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-15-1983, to 1-21-1983, that (I) (we) last saw the deceased alive on 1-20-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Harold E. Ramsey, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-21-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD E. RAMSEY						22e. ADDRESS 301 McMEHEN ST. BALTIMORE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/83		23c. NAME OF CEMETERY OR CREMATORY Md Nat Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md							
24. FUNERAL DIRECTOR NAME Wm. C. March F.H.						25a. DATE REC'D. BY REGISTRAR JAN 24 1983		25b. REGISTRAR'S SIGNATURE J. Ann J. Connelley					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				5005 DICKEY HILL RD. BALTIMORE, MD 21201			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Baby Girl A Bouldin				1/13/83			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		B		1/13/83		11 30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto, md		USA				City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto, md		Sinai Hospital					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5005 Dickeyville Rd. 21227	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Melvin D Warren				Leah Bouldin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) nonviable premature infant							
7650 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
None				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/13/83, 1983, to 1/13, 1983, that (I) (we) lost the deceased alive on 1/13/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
J. BURG						1/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
J. BURG				Sinai Hosp. Balto, md			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
CREMATION		1-20-83		Sinai Hospital		Baltimore, Md	
24. FUNERAL DIRECTOR				25. DATE RECD. BY REGISTRAR			
NAME				ADDRESS			
				MAR 9 1983			



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1. DECEASED NAME (TYPE OR PRINT) <b>Baby girl B Bouldin</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/13/83</b>		2b. HOUR <b>1130 PM</b>
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 13 83</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>newborn</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>-----</b> 13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5005 Dickeyville Rd. 21227</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>melvin O Warren</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Bouldin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>nonviable premature infant</b> <b>7650</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs 55 min.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>83</b> , to <b>1/13</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <b>J. BORG</b> DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/14/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. BORG</b>		22e. ADDRESS <b>Sinai Hospital, Balto, md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>1-20-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sinai Hospital Baltimore, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS		15a. DATE REC'D. BY REGISTRAR, REGISTRAR'S SIGNATURE <b>MAR 9 1983</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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John Young & Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 721 Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 0 0 7 2 3			
1. FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alice Louise Bowen</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 83</b>			
3. SEX <b>Female</b>					2b. HOUR <b>7<sup>PM</sup></b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 17, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Harrisonburg, VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1121 N Calvert Street 21202</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Cowan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida N/A</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>213-92-9256</b>		17. INFORMANT ADDRESS <b>Mary C. Hutton, P. O. Box 125, Tilghman, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>4589</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MULTISYSTEM ORGANO FAILURE, ACUTE PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPOTENSION, SEPSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b> <b>3 DAYS</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>MYOTONIC GRAVIS, CARDIAC ARRHYTHMIAS, HEART FAILURE</b>								
19a. DATE OF OPERATION <b>1/14</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COLIC, GASTROENTERITIS, BILE DUCT</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> , 19 <b>82</b> , to <b>1/17</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/17</b> , 19 <b>83</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above.								
22b. SIGNATURE <b>James Lawrence Hutton</b>				DEGREE <b>MD</b>		22f. DATE SIGNED <b>1/17/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. L. Fitzpatrick M.D.</b>				22e. ADDRESS <b>Dept of Surgery Mercy Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>20 Jan 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie AA MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>James S. Kirkley, Glen Burnie, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

BP

917-100-01



One of the following is the name of the person who is the owner of the land described in the foregoing

and the name of the person who is the owner of the land described in the foregoing

and the name of the person who is the owner of the land described in the foregoing

and the name of the person who is the owner of the land described in the foregoing

and the name of the person who is the owner of the land described in the foregoing

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 0 0 7 2 4				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VERA BOWMAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 17 83</b>			2b. HOUR <b>3 15 AM</b>	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 01 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 3235 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>					16b. SOCIAL SECURITY NO. <b>215-32-0059</b>		17. INFORMANT ADDRESS <b>Office On Aging 301 W. Preston St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable hypernephroma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1890</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED (WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)				
22a. I certify that (I) this hospital attended the deceased from <b>11/18</b> 19 <b>82</b> to <b>1/17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Gregory Lanpher</b> DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory Lanpher</b>					22e. ADDRESS <b>Lutheran Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>BURIAL</b>			23b. DATE <b>1/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moun Zion Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>March Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>				
					REGISTRAR'S SIGNATURE <b>John J. Conner</b>				

BP

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 / 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT NAME) FIRST MIDDLE LAST <b>HATTIE BOYD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>01 29 83</b>		2b. HOUR <b>1:30 A</b>	
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 24 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Luke Henderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Low</b>		16. STREET ADDRESS <b>1940 Vine St. 21223</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>245-30-5705</b>		17. INFORMANT ADDRESS <b>Amie Rice 1847 W. Lexington Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>7991</b> IMMEDIATE CAUSE (a) <b>Respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>1/15 83 to 1/29 83</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15 83</b> to <b>1/29 83</b> , that (we) last saw the deceased alive on <b>1/28 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>DAN MORTON</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/29/83</b>	
22d. PHYSICIAN'S NAME (Type or Print) <b>DAN MORTON</b>		22e. ADDRESS <b>Lutheran Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc. 1101 E. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300126

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Henry E. Boyd		1-28-83	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
m	negro	12 31 40	42
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
S.C.	U.S.A.		BALTO. CITY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BALTO.	Good Sam	Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
md.		BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
Henry E. Boyd Sr.	Margie Mayers	1612 HARTSDALE Rd #21239	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	220-36-6033	MRS. MARGIE MAYERS	1612 HARTSDALE Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4140 Acute coronary disease			1 min.
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery atherosclerosis 6 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):			
Aortic insufficiency			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	P.M. 19		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/6/77 to 1/2/83, that (I) (we) lost saw the deceased alive on 12/10/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Elijah Saunders, M.D.	M.D.		1/31/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Elijah Saunders, M.D.	Village of Cross Keys 2 Hamill Road, Baltimore, MD 21210		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/3/83	Archbas Mem. Pk.	BALTO. MD.
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Betts Funeral Home	1129 N. Caroline St.	JAN 31 1983 John J. Connel	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00727

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE E BOYD			2a. DATE OF DEATH MONTH DAY YEAR 1 16 83		2b. HOUR 4:10 A.M.
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 3 33		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE NO		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LUKE SMITH Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vantilear Wright		13e. STREET ADDRESS 4975 DENIMORE AVE 21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-30-7059		17. INFORMANT ADDRESS Luke Smith, Sr. 2119 Longwood Street	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA		15 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CA, T-E FISTULA S/P RAD Tx		> 5 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 12/30/82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF ESOPHAGUS	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12/28, 1982, to 1/16, 1983, that (I) (we) last saw the deceased alive on 1/16, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE Guillermo W. Arnaud MD		22c. DATE SIGNED 1/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUILLERMO W. ARNAUD		22e. ADDRESS UNIVERSITY HOSPITAL 22 S. GREENE ST. 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/21/83	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North avenue		25a. DATE REC'D. BY REGISTRAR JAN 18 1983	25b. REGISTRAR'S SIGNATURE John J. Canine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1972



FILE 7/16

20% COLLECT





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 2 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRVIN E. BOYER SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 18 83</b>		2b. HOUR <b>/ AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 29 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1213 WASHINGTON BOULEVARD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AUTO SALESMAN</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>---</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES WILBUR BOYER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MILLICENT MAY DELCHER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-10-4332</b>		17. INFORMANT ADDRESS <b>JAMES L. BOYER 6012 CLAIRE ROAD, 21227</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Sudden

One month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pulmonary Embolism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> , 19 <b>80</b> , to <b>1/18</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <b>John P. Urlock Jr.</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>1/18/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN P. URLOCK, JR., M.D.</b>		22e. ADDRESS <b>1227 WASHINGTON BOULEVARD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>01-21-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PARK</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>GLEN BURNIE A.A. MARYLAND</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



21229  
JAN 20 1983  
GLEN HAVEN MEMORIAL GLEN LORNE A.A. MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 0 7 2 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alice G. Boyle</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 14 83</b>		2b. HOUR <b>9:30 AM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>schoolteacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>elementary</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS <b>1100 Taylor Avenue 21227</b>	
13a. STATE <b>Md</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. STREET ADDRESS <b>1100 Taylor Avenue</b>		13e. ZIP CODE <b>21227</b>	
14. FATHER'S NAME (TYPE OR PRINT) <b>Thomas Joseph Tobin</b>				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Mary Elizabeth O'Connell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>112 16 6375</b>		17. INFORMANT ADDRESS <b>Alice Duvall same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) Pleural effusion and CHF</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA aphasia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 21</b> , 19 <b>82</b> , to <b>Jan 14</b> , 19 <b>83</b> , that (I) (we) lost <b>Jan 4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Julian W. Reed M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/14/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN W. REED M.D.</b>				22e. ADDRESS <b>811 S. CHAS ST. 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 17, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowdridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Homes, Laurel, Md</b>				25a. DATE REC'D. BY REGISTRAR (M. REGISTRAR'S SIGNATURE) <b>JAN 21 1983 John J. Carver</b>			

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John H. Watson Medical Center  
1100 E. 10th Avenue  
Denver, Colorado 80202  
Phone: 333-1111

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1/1/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

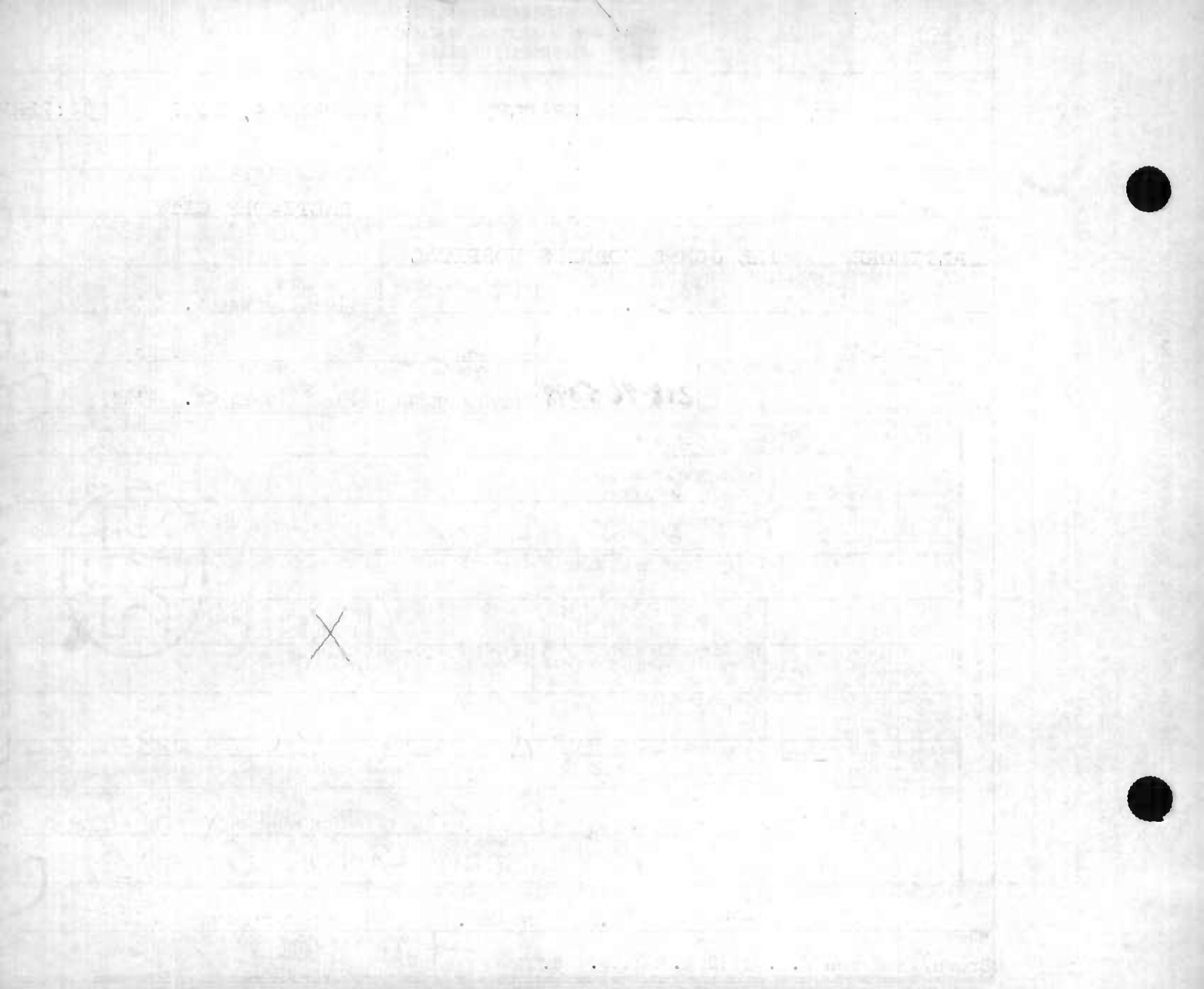
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300730

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILBERT LEE BRADLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 4, 1983</b>			2b. HOUR <b>04:22AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 MONTH 7 DAY 48 YEAR</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nathaniel Bradley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Morgan</b>		16. STREET ADDRESS <b>1610 Liljones Ct. 21237</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-46-5398</b>		17. INFORMANT ADDRESS <b>Helen Morgan 1610 Liljones Ct. 21237</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>5713</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastrointestinal bleed</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholic Liver disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>24 hrs</b> <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>82</b> , to <b>1/4</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/4</b> , 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Sigmond</b>				22c. DATE SIGNED <b>1/4/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM SIGMOND</b>	
22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				22f. DATE REC'D BY REGISTRAR 22g. REGISTRAR'S SIGNATURE <b>JAN 6 1983 John J. [Signature]</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-7-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brown/Thompson F.H. 1913 W. Balto. St.</b>							



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 83 00731						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Amelia E BRANNAN			2a. DATE OF DEATH MONTH DAY YEAR 1 27 83			2b. HOUR 12:45 AM
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 15 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Rudolph Hrebik			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kadlec			13e. STREET ADDRESS 3629 E. Fayette St. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charles Hrebik 530 N. Kenwood Ave 21205				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>SEPSIS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Gastrocnemius Small Bowel, Atherosclerotic Heart Disease, Diabetes</u>									
19a. DATE OF OPERATION 12/26/82 1/7/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Sepsis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/20 1982 to 1/27 1983, that (I) (we) lost saw the deceased alive on 1/23/83 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Fitzpatrick MD					DEGREE M.D.			22c. DATE SIGNED 1/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Fitzpatrick M.D.					22e. ADDRESS Mercy Hosp Dept of Surgery				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-29-83		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ZANNINO FUN. HOME					25a. DATE REC'D. BY REGISTRAR JAN 28 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		

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MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 00732					
FOR 1. STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
BABY BOY BRATCHER				JANUARY 30, 1983				06:26AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		NEGRO		MONTH DAY YEAR 1 28 83		—		YRS. 2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Del.		USA				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL				INFANT			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Q.A.		PONDSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PONDSTOWN MD 21651	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7469 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE CARDIAC DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 1 1/2 days	
WALDEN GREGORY		BARRY		Cherry		Venita		BRATCHER	
16a. (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMATION		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		—		MOTHER					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
NONE KNOWN									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
NONE		NONE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4:20 AM 30 JAN 19 83 to 10:26 AM 30 JAN 83, that (I) (we) lost saw the deceased alive on 30 JAN 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Elizabeth W. MURKIN				MD				30 Jan '83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
ELIZABETH W. MURKIN				12711 MISTOCK LN UPPER MARLBORO, MA 02072					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-2-83		MT. PLEASANT Cem.		PONDSTOWN Q.A. MD			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
EDW. FELLOWS & SON F.H. MILLINGTON MD				FEB 16 1983		John J. Carver			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 3 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH JAMES BRIDGES</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>06-22-83</b>		2b. HOUR <b>6<sup>20</sup> P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Operator</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bridges</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Jones</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>215-10-0671</b>		17. INFORMANT ADDRESS <b>21223</b>		17. INFORMANT ADDRESS <b>Florence Bridges 1138 Sargeant Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>1850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of the prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>5 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.							
19a. DATE OF OPERATION <b>1/10/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pathologic Fracture of right femur</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>82</b> , to <b>1/22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dean Mitchell, MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dean Mitchell</b>		22e. ADDRESS <b>3001 S. Hanover St. Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 3 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Howard</b>	MIDDLE <b>I.</b>	LAST <b>Brisbois</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>1-12-83</b>		2b. HOUR <b>9:33p</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 15, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4206 Anntana Ave. (Residence)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4206 Anntana Ave. 21206</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Brisbois</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Allan</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Army WW II 215-01-6483</b>		17. INFORMANT <b>Thelma V. Brisbois</b>		ADDRESS <b>4206 Anntana Avenue</b>		

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

1509  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CANCER OF THE ESOPHAGUS with METASTASIS TO THE LIVER**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 4</b> , 19 <b>83</b> , to <b>JAN. 12</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>JAN. 12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Lydia M. Jumamoy, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lydia Jumamoy, M.D.</b>				22e. ADDRESS <b>Church Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 17 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>				25a. DATE RECD. BY REGISTRAR <b>JAN 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Ret. Main Branch

(Insurance)

James T. Smith 4000 American Avenue

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James T. Smith

Ret. Main Branch

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
Clea Esther Brock			1			15			83						M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female			Black			1 1 24			58			YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
N. Carolina			U.S.A.						Baltimore city			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore			702 East 21st. Street														

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
			Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			702 E. 21st Street 21218		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST			FIRST MIDDLE LAST														
Nat Brock			Lula Mae Todd														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			049-48-2461			Catherine Brock Spigner			18 Waverly								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u>		<u>5 weeks</u>	
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	
<u>SERENA R. NOLAN MD</u>			
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
1-17-83		SERENA R. NOLAN, M.D.	
22e. ADDRESS		22f. ADDRESS	
		2149 KIRK AVENUE, BALTIMORE, MD 21218	

23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		1/20/83		Todd Family Cem.		Wake Co. N.C.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
Wm.C. March f/H Inc. 1101 E. North Ave.				JAN 17 1983			
ADDRESS				25b. REGISTRAR'S SIGNATURE			
				<u>John J. Connel</u>			





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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 3 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS BROGDEN			2a. DATE OF DEATH MONTH DAY YEAR 1 16 83			2b. HOUR 2:35 p.m.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, AMRYLAND 21218				12a. USUAL OCCUPATION (IF WORKER FOR MOST OF WORKING YEARS) DRIVER BALT. MDV	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN ANN ARUNDEL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5844 Race Road Elkridge	
14. FATHER'S NAME FIRST MIDDLE LAST HERBERT E. BROGDEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUVINIA GREEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN, WRITE "UNKNOWN") YES		16b. SOCIAL SECURITY NO. KOREAN 217-26-6990		17. INFORMANT ADDRESS BALT. MD. ESTELLE M. BROGDEN 5844 RACE ROAD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1641 IMMEDIATE CAUSE (a) Respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) pericardial metastases		1 month	
DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma of unknown primary		2 month	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from DECEMBER 22, 19 82, to JANUARY 16, 1983, that (we) lost saw the deceased alive on JANUARY 16, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Minkove				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Minkove				22e. ADDRESS 3500 Loch Raven Blvd. BALT., MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-21-83		23c. NAME OF CEMETERY OR CREMATORY BALT. NAT.		23d. LOCATION (CITY OR TOWN) COUNTY STATE BALT. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS NUTTER FUNERAL HOME 3035 W. NORTA AVE				25a. DATE REC'D. BY REGISTRAR JAN 19 1983			
				25b. REGISTRAR'S SIGNATURE John J. Connel			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED  
MAY 19 1964  
U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 3 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Fannie M. BROOKS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 16 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. DAVIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Palmer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>129-26-2162</b>		17. INFORMANT ADDRESS <b>Mrs. Ida Jiggetts 4102 FAIRFAX AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4141</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis, and Severe coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ventricular Aneurysm.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 1, 1982</b> , to <b>January 11, 1983</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 11, 1983</b> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mohammed Aslam M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mohammad Aslam, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO Md.</b>	
24. FUNERAL DIRECTOR NAME <b>JAS. A. MORTON + SONS</b>				ADDRESS <b>1701 Laurens</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

JAN 17 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William R. Broll</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 13, 1983</b>			2b. HOUR <b>4:45 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 1 '76</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fgt. &amp; Exp.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1613 Locust Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES E. Broll</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MODELINE = Weaver</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>A-216-07-4882</b>		17. INFORMANT <b>Mary Broll</b>		ADDRESS <b>same as above</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1709 IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u></b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC CHONDROSARCOMA OF THE FOOT</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James T. Hewler, M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/13/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James T. Hewler, M.D.</b>				22a. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/17/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie. A.A. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

BP

1. The purpose of this report is to provide a summary of the activities of the Office of the Chief of Staff during the period from 1 January 1968 to 31 December 1968. The report is organized into four main sections: (a) General Information, (b) Major Activities, (c) Personnel, and (d) Financial. The following information is provided for each section:

2. General Information: The Office of the Chief of Staff was established on 1 January 1968. It is located at the Department of the Army, Washington, D.C. The Office is headed by the Chief of Staff, who is responsible for the overall management and coordination of the Office's activities. The Office is composed of several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

3. Major Activities: The Office of the Chief of Staff has been actively involved in a number of major activities during the year. These activities include the development and implementation of the Department of the Army's strategic plan, the coordination of the Department's response to the Vietnam War, and the management of the Department's budget. The Office has also been involved in a number of other activities, including the development of the Department's policy on the use of nuclear weapons, the coordination of the Department's response to the Cuban Missile Crisis, and the management of the Department's response to the Suez Canal Crisis.

4. Personnel: The Office of the Chief of Staff has a total of 1,200 personnel. This includes 800 military personnel and 400 civilian personnel. The personnel are organized into several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

5. Financial: The Office of the Chief of Staff has a total of \$100 million in funds available for its activities. This includes \$50 million in appropriated funds and \$50 million in unappropriated funds. The Office has been actively involved in the management of these funds, ensuring that they are used in accordance with the Department's policies and procedures.

6. The following information is provided for each section:

7. General Information: The Office of the Chief of Staff was established on 1 January 1968. It is located at the Department of the Army, Washington, D.C. The Office is headed by the Chief of Staff, who is responsible for the overall management and coordination of the Office's activities. The Office is composed of several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

8. Major Activities: The Office of the Chief of Staff has been actively involved in a number of major activities during the year. These activities include the development and implementation of the Department of the Army's strategic plan, the coordination of the Department's response to the Vietnam War, and the management of the Department's budget. The Office has also been involved in a number of other activities, including the development of the Department's policy on the use of nuclear weapons, the coordination of the Department's response to the Cuban Missile Crisis, and the management of the Department's response to the Suez Canal Crisis.

9. Personnel: The Office of the Chief of Staff has a total of 1,200 personnel. This includes 800 military personnel and 400 civilian personnel. The personnel are organized into several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

10. Financial: The Office of the Chief of Staff has a total of \$100 million in funds available for its activities. This includes \$50 million in appropriated funds and \$50 million in unappropriated funds. The Office has been actively involved in the management of these funds, ensuring that they are used in accordance with the Department's policies and procedures.

11. The following information is provided for each section:

12. General Information: The Office of the Chief of Staff was established on 1 January 1968. It is located at the Department of the Army, Washington, D.C. The Office is headed by the Chief of Staff, who is responsible for the overall management and coordination of the Office's activities. The Office is composed of several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

13. Major Activities: The Office of the Chief of Staff has been actively involved in a number of major activities during the year. These activities include the development and implementation of the Department of the Army's strategic plan, the coordination of the Department's response to the Vietnam War, and the management of the Department's budget. The Office has also been involved in a number of other activities, including the development of the Department's policy on the use of nuclear weapons, the coordination of the Department's response to the Cuban Missile Crisis, and the management of the Department's response to the Suez Canal Crisis.

14. Personnel: The Office of the Chief of Staff has a total of 1,200 personnel. This includes 800 military personnel and 400 civilian personnel. The personnel are organized into several major components, including the Office of the Assistant Chief of Staff for Operations and Plans, the Office of the Assistant Chief of Staff for Personnel, and the Office of the Assistant Chief of Staff for Financial Management.

15. Financial: The Office of the Chief of Staff has a total of \$100 million in funds available for its activities. This includes \$50 million in appropriated funds and \$50 million in unappropriated funds. The Office has been actively involved in the management of these funds, ensuring that they are used in accordance with the Department's policies and procedures.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300739

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie Amanda Brown			2a. DATE OF DEATH MONTH DAY YEAR January 27, 1983		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 5, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 3 Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2702 Overland Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2702 Overland Avenue 21214	
14. FATHER'S NAME FIRST MIDDLE LAST James Littleberry Palmore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Camden Waldrop			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-2704		17. INFORMANT ADDRESS Mrs. Mildred L. Hale Same	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 74, to 19 83, that (I) (we) lost saw the deceased alive on 1/27/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Gracito Patricio M.D.	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gracito Patricio MD	22e. ADDRESS 2926 E. Cold Spring Lane Balto. Co.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 31, 1983	23c. NAME OF CEMETERY OR CREMATORY Riverview	23d. LOCATION CITY OR TOWN COUNTY STATE Richmond Virginia
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 28 1983	25b. REGISTRAR'S SIGNATURE John J. Connelley

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

83 00740

1. DECEASED NAME (TYPE OR PRINT) <b>CORTLANDT L. BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 22 83</b>			2b. HOUR <b>M</b>		
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MUSIC</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL BROWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA SCOTT</b>			13e. STREET ADDRESS <b>2601 MADISON AVE., BALT., MD.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-05-7957A</b>		17. INFORMANT ADDRESS <b>RUTH B. BROWN-2601 MADISON AVENUE BALTIMORE, MD.</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>7310</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Paget's Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> , 19 <b>82</b> , to <b>1-21-</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-21-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Percival P. Smith</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-25-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CO., MD.</b>		
24. FUNERAL DIRECTOR NAME <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE. #21216</b>				25a. DATE REC'D BY REGISTRAR <b>JAN 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00741

FOR  
STATE  
REGISTRAR

REG. NO.

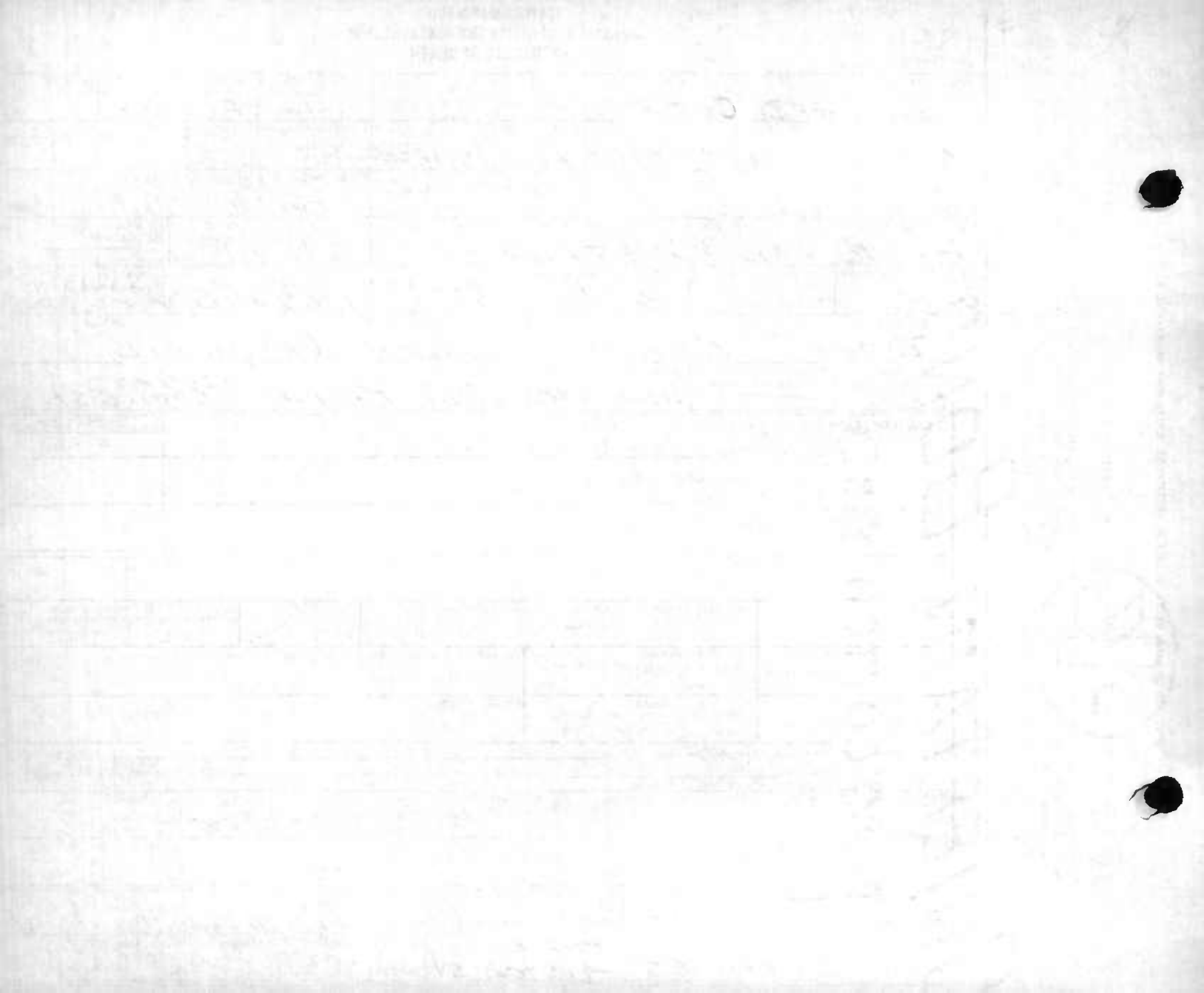
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD C. BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 8, 1983</b>			2b. HOUR M				
3. SEX <b>MALE</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 25, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1204 N. SPRING ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1204 N. Spring St. 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVE BROWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA CALDWELL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-07-6428</b>		17. INFORMANT ADDRESS <b>Lillie BROWN 1204 N. SPRING ST.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Ischemic CA</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>1850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALWORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 82</b> , to <b>Dec 8 19 83</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Donald Diver M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/4/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAN DIVER</b>			22e. ADDRESS <b>The Johns Hopkins Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-14-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>mt. Calvary Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel County, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>CALVIN B. SCRUGGS</b>			ADDRESS <b>1412 E Preston St</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Conner</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 000 / 42			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Hilson Brown				2a. DATE OF DEATH MONTH DAY YEAR 1 1 83		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 19 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 500 Dolphin Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 500 Dolphin Street 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Collins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-34-2173		17. INFORMANT ADDRESS Robert C. Hilson 10726 Evening Wind Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 <i>THASCD</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute myocardial infarction recent</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yes</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1979</i> , 19 <i>1982</i> , that (I) (we) last saw the deceased alive on <i>December 30, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ruperto Mananquil</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-4-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RUPERTO MANANKIL</i>				22e. ADDRESS <i>1618 W North Ave.</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 1/5/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/h Inc. 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 6 1983			
				25b. REGISTRAR'S SIGNATURE <i>John J. Lough</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 4 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Geneva Brown (Shedd)</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01 11 83</b> 2b. HOUR <b>9<sup>40</sup> A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lou.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>5547 Force Road 21239</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>- - -</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geneva - - -</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>266-34-4681</b>		17. INFORMANT ADDRESS <b>Jean Boyd 5547 Force Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lung Small cell carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>1629</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from <b>1/11</b> , 19 <b>83</b> , to <b>1/11</b> , 19 <b>83</b> , that (b) we lost above (c) we (did) (did not) view the body after death.							
22b. SIGNATURE <b>Karen E Friday</b> DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRIDAY</b>				22e. ADDRESS <b>Baltimore City Hospitals</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 4 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD LINCOLN BROWN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 20 83</b>		2b. HOUR <b>4:45A</b> M	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Lucas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215 28 7404</b>		17. INFORMANT ADDRESS <b>Vera Dearing 2312 Koko Lane 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: <b>CARDIO PULMONARY ARREST</b> <b>1455</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC SQUAMOUS CELL CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION <b>Oct 29, 1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of palate</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <b>October 18, 1982</b> , to <b>January 20, 1983</b> , that (X) (we) lost <b>saw the deceased alive on January 20, 1983</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Russell Wright Jr.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Russell Wright Jr.</b>				22e. ADDRESS <b>3900 Loch Raven Blvd. Balto. Md 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vat. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brown/Thompson F.H. 1913 W. Balto.St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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FOOT COTTON

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 4 5

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES HUGH BROWN</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>3</b> YEAR <b>83</b>			2b. HOUR <b>6:57 A.M.</b>					
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>22</b> YEAR <b>16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>				12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>CHECKER-TIN MILL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BETHLETHEN SEA</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>BALTIMORE</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5122 NORWOOD AVE. BALT. MD. 21207</b>			
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b></b> LAST <b>BROWN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LEVENIA</b> MIDDLE <b></b> LAST <b>SILSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>212-14-4432</b>		17. INFORMANT ADDRESS <b>RUSSELL BROWN - 1719 E. 30th St. BALT. MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-17</b> , 19 <b>82</b> , to <b>1-3</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-3</b> , 19 <b>83</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Daniel M. Perlman</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/3/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL M. PERLMAN</b>				22e. ADDRESS <b>BALTIMORE CITY HOSPITALS BALTIMORE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WETIPACU, FRIENDSHIP MTH WICOMICO</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>HERBERT E. NUTTER - 3035 W. NORTH AVE.</b> ADDRESS <b></b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JESSIE (JESSE) BROWN				2a. DATE OF DEATH MONTH DAY YEAR 1 21 83			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 5 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Felton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 01 8366		17. INFORMANT ADDRESS Apt. 213 Mendozaia Brown 201 N. Washington St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>5772</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>PANCREATIC PSEUDOCYST</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 28</u> , 19 <u>82</u> , to <u>January 21</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 21</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <u>C. J. Cousar</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/21/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. J. COUSAR</u>				22e. ADDRESS <u>3900 Loch Raven Blvd. Balto. Md 21218</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>1-26-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Md Veteran Cemetery Crownsville Md</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR <u>JAN 24 1983</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

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JAN 17 1940



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JAN 17 1940

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Leroy			Brown			1 8 19 83						3:05			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. MARRIED	
Male		Black		7 14 34		48		MONTHS		DAYS		1 8 19 83		A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH			
S.C.				USA				WIDOWED				Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				Union Memorial Hospital											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
MD								Baltimore				YES X NO			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
Edward				Lottie				No				249-46-4661			
17. INFORMANT				17. ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Rose M. Brown				1924 E. 29th St.				1629 Carcinoma of Lung							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES NO X							
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED							
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK NOT WHILE AT WORK				STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an				Autopsy Inspection Inquiry				and in my opinion							
death resulted from:				Natural causes Accident Suicide Homicide Undetermined manner											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Hormez R. Guard, M.D.				M.D. Assistant				1/11/83							
EXAMINER'S NAME				ADDRESS				23a. BURIAL, CREMATION, REMOVAL				23b. DATE			
(TYPE OR PRINT)				111 Penn St., Balto., Md.				Burial				1/13/83			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
Baltimore Cem.				Baltimore				Wm. C. March F/H				JAN 11 1983			
NAME				ADDRESS				25b. REGISTRAR'S SIGNATURE							
1101 E. North Ave.								John J. Canfield							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

MEMORANDUM FOR THE RECORD

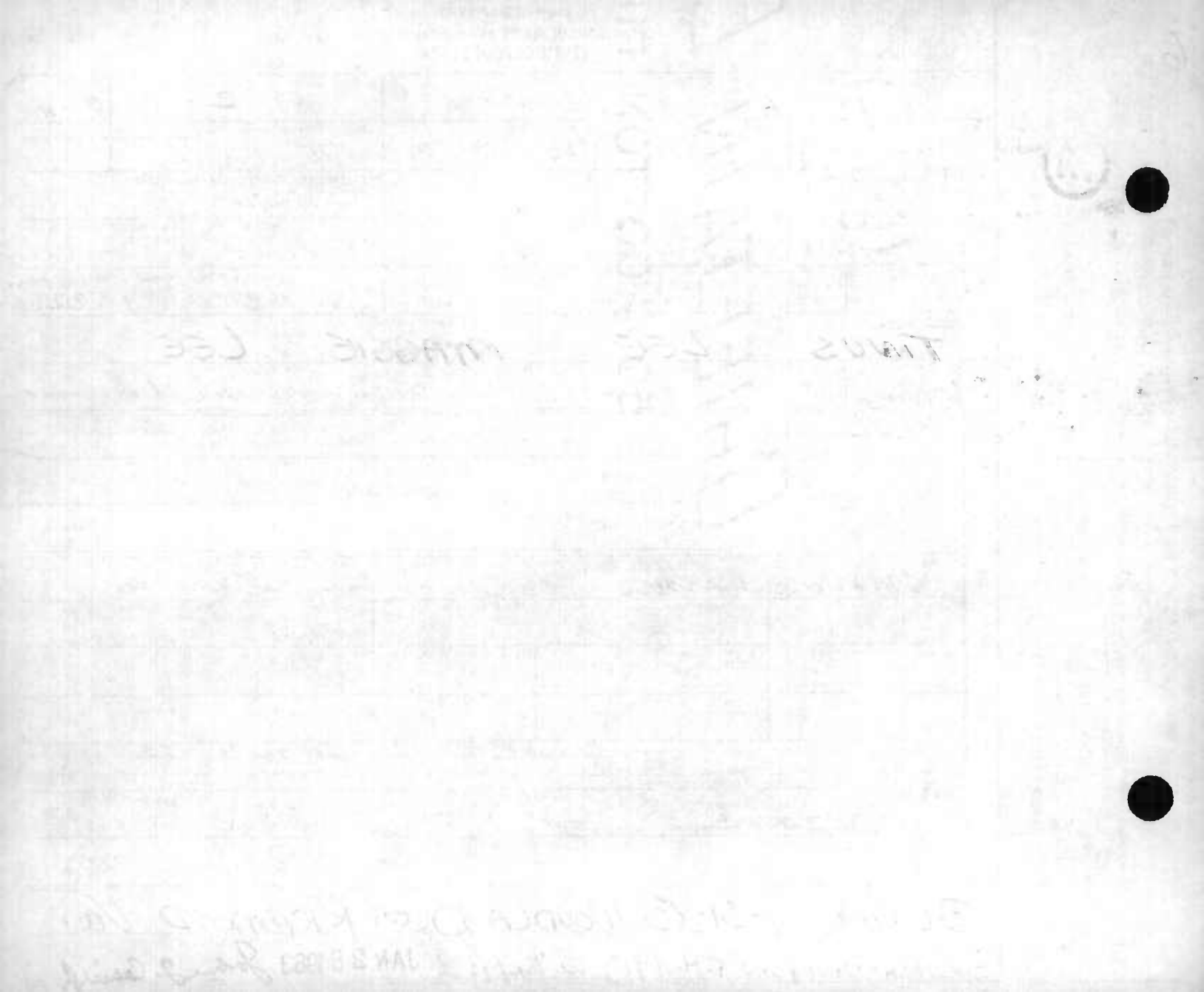


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 83 00748									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARRIA		MIDDLE L		LAST BROWN		2a. DATE OF DEATH MONTH DAY YEAR 01-26-83		2b. HOUR 0:15 AM	
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 04 27 07		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1501 N. Dukeland St. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST TINUS LEE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE LEE				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown					
16b. SOCIAL SECURITY NO. 226164657		17. INFORMANT Wesley Shelton				17. ADDRESS 1916 Cedric Rd Baltimore					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Hypertension, Multiple Cerebrovascular accidents										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from December 31, 1982, to January 26, 1983, that (I) (we) lost saw the deceased alive on January 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-26-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Claudio F. Lavata		22e. ADDRESS Lutheran Hospital, Baltimore, Md 21216									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1-31-83		23c. NAME OF CEMETERY OR CREMATORY Woodland				23d. LOCATION CITY OR TOWN COUNTY STATE Richmond Va			
24. FUNERAL DIRECTOR NAME BROOK H. Thompson		F.H. 1913 W. BALTO ST.		25a. DATE REC'D BY REGISTRAR JAN 28 1983		25b. REGISTRAR'S SIGNATURE [Signature]					



Item 1G577 3/22/83JAB

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pursie (Perry) Brown			2a. DATE OF DEATH MONTH DAY YEAR 1/19/83		2b. HOUR 6:00 AM
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 12 37		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST N/A			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nanie Monterior		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-5659		17. INFORMANT ADDRESS Bernice Brown 1824 E. Eager Street.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 3481 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Neurologic Damage 20 ANOXIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pneumonia, left lower lobe infiltrate, Diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/6/83 to 1/19/83, that (I) (we) last saw the deceased alive on 1/19/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rodolph E. Merick		DEGREE Md.		22c. DATE SIGNED 1/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodolph E. Merick		22e. ADDRESS c/o Baltimore City Hospital, Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/24/83		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery	
23d. LOCATION CITY OR TOWN Crownsville		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. north Avenue		25a. DATE REC'D. BY REGISTRAR JAN 20 1983			
ADDRESS		REGISTRAR'S SIGNATURE John J. Carver			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



12

CHITRA

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 5 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA L BROWN			2a. DATE OF DEATH MONTH DAY YEAR 01 08 83			2b. HOUR 8:15 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 07 21 33		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNT.	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST VERNON SMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELVEY CHAMBERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 279-32-1385		17. INFORMANT ADDRESS GEORGE BROWN 2550 HARLEM AVE. 21216			

## 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrhythmia

3940

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) mitral stenosis

DUE TO, OR AS A CONSEQUENCE OF

(c) rheumatic heart diseaseAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Septicemia, pulmonary embolism, severe ileus, severe ascites

19a. DATE OF OPERATION 12-10-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED/ mitral stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> 19 <u>83</u> , to <u>1-8</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sergio Tavares</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-8-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SERGIO TAVARES				22e. ADDRESS University Hospital			

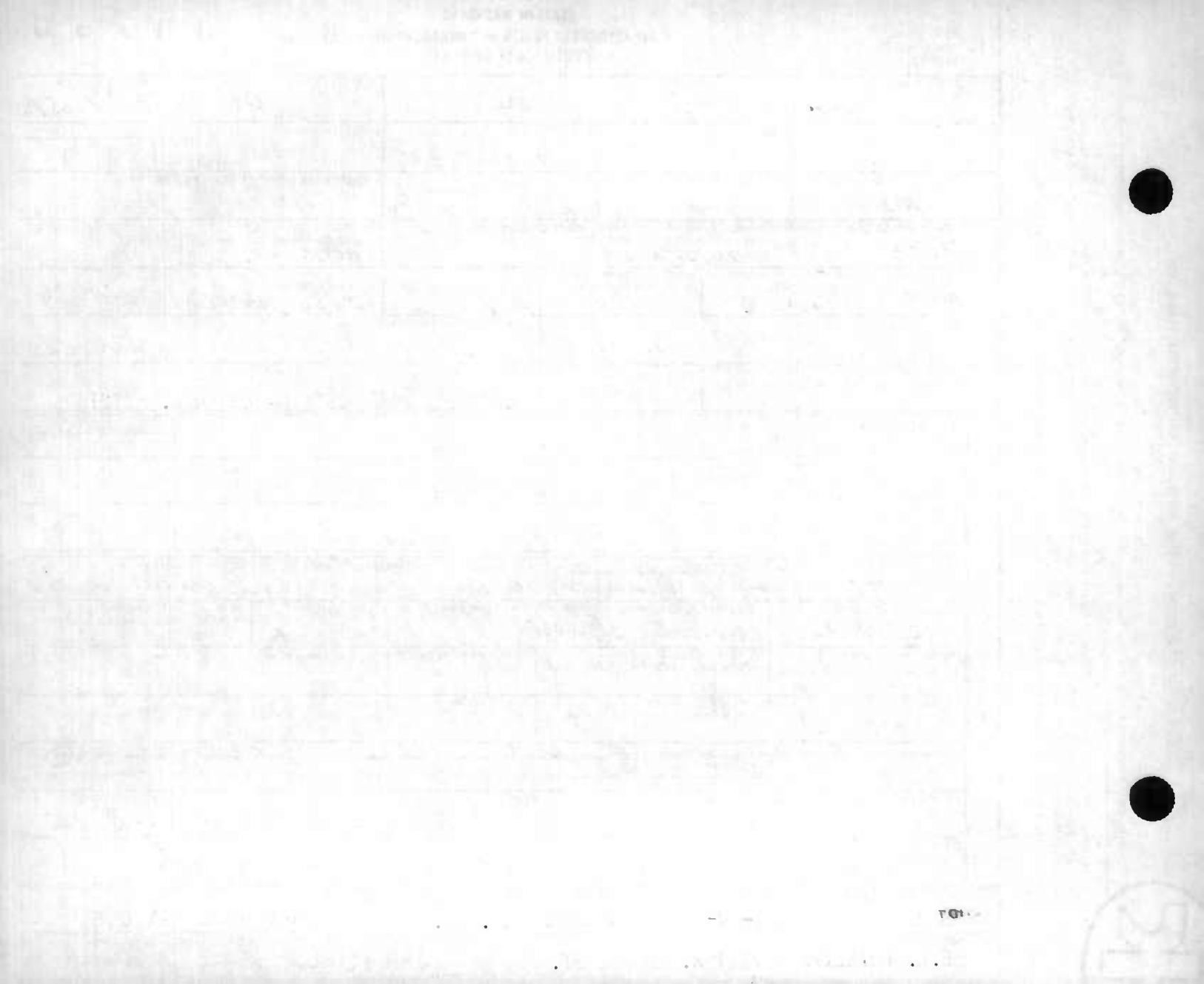
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-14-83		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS 1721 N. MONROE ST.				25. DATE REC'D. BY REGISTRAR JAN 10 1983			
				26. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 5 1			
FOR 1 - STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIVIAN E. BOWEN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 83</b>		2b. HOUR <b>6<sup>00</sup></b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 21 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) <b>Lumber Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Bus.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wally Bowen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown King</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-07-5965</b>		17. INFORMANT ADDRESS <b>Isaac E. Bowen 7657 3rd Ave. 21061</b> <b>Glen Burnie, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> 5319 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pth. gastrectomy for bleeding ulcer - Haematoma</b>							
19a. DATE OF OPERATION <b>1-18-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gastric ulcer -</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-8-</b> 19 <b>83</b> , to <b>1-27-</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-27-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Georg J. Vellankaran M</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-27-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. VELLANIKARAN MD</b>				22e. ADDRESS <b>St. Agnes Hospital Baltimore - MD - 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/31/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>				24b. ADDRESS <b>21229 4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>			

BP \_\_\_\_\_





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH E. BROWNLEE				2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 17 83				2b. HOUR M 3:17 PM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 6 32	6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 17 83		2d. HOUR M 3:17 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3202 MONDAWMIN AVE. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST LEROY JACKSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVA PARRISH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JOHN BROWNLEE 3202 MONDAWMIN AVE. 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-18-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1-22-83		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION BALTIMORE COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS				ADDRESS 1721 N. MONROE ST.		25. DATE REC'D. BY REGISTRAR JAN 20 1983			
				REGISTRAR'S SIGNATURE 					

RECEIVED  
OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS  
WASHINGTON, D.C.

(M)

RECEIVED  
OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS  
WASHINGTON, D.C.

(27)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 5 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST AGNES C. BRUCE			MONTH DAY YEAR JANUARY 27, 1983			1:15 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR 1/ 13 1906	77 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Church Hospital Corporation			Housewife				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Baltimore			River		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Adam Schmitt			Agnes Schmitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			214-46-1346			Margaret C. Campbell-Balto., MD. 21220		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PULMONARY EDEMA: ACUTE CEREBROVASCULAR ACCIDENT (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from JANUARY 26, 19 83, to JANUARY 27, 19 83, that (I) saw the deceased alive on JANUARY 27, 19 83, and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.			DEGREE			22c. DATE SIGNED		
22b. SIGNATURE Walker Impagliatelli						1/27/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI, M.D.			22e. ADDRESS CHURCH HOSPITAL 100 NORTH BROADWAY, BALTIMORE, MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			1/31/1983		Oak Lawn		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE OF REGISTRATION			25b. REGISTRAR'S SIGNATURE		
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222			JAN 28 1983			[Signature]		

MEDICAL CERTIFICATION



11/11/11

11/11/11

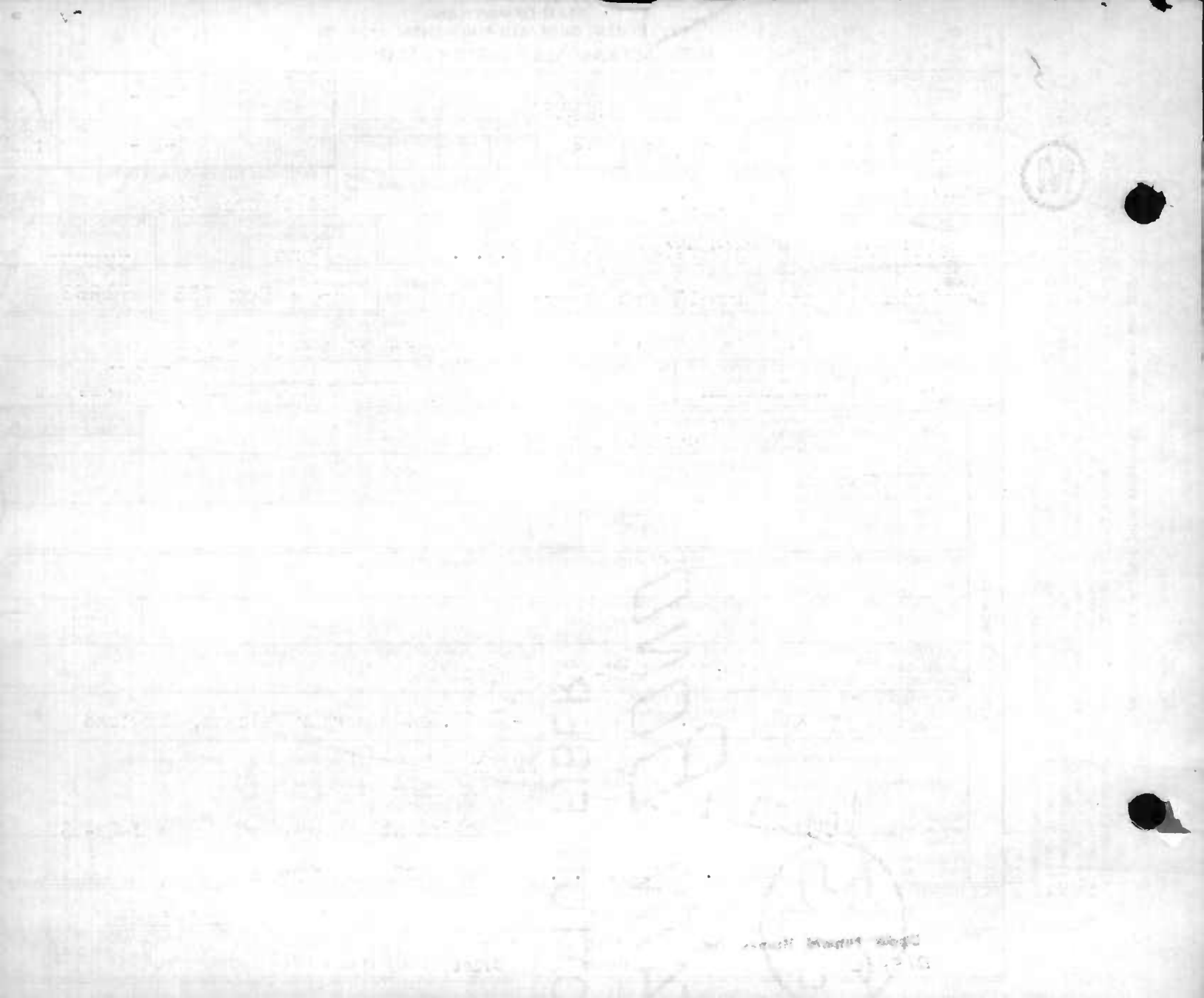
11/11/11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00754	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
			GARY Lee BRUMLEY			1-28-83			19		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD	
Male		White		Aug 23, 57		25 YRS.		MONTHS DAYS HOURS MIN		1-28-83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Louisiana			U.S.A.						Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			University Hospital S.T.U.			None			-----		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Louisiana			West Carroll			Oak Grove			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
H. B. Tripp			Glenda Pickering Rios			No			71263		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Stephen Cox Oak Grove, Louisiana			71263			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head					
						DUETO, OR AS A CONSEQUENCE OF					
						(b) DUETO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			10:50AM 1-28-83			subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
			hgwy.			I-95&13.6mile marker Belcamp, Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Margarita A. Korell, M.D.			M.D. Assistant			1-29-83					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
			111 Penn Street			Burial			Feb 2, 83		
24. FUNERAL DIRECTOR NAME			24c. NAME OF CEMETERY OR CREMATORY			24d. LOCATION CITY OR TOWN			24e. STATE		
DIPPEL			Buluah Cemetery			Buluah, Louisiana					
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE REC'D. BY REGISTRAR			25d. REGISTRAR'S SIGNATURE		
JAN 31 1983			John J. Carver								



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 5-5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS W BRUNNER			2a. DATE OF DEATH MONTH DAY YEAR 1/9/83 6 14 27		2b. HOUR 145A M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6 14 27	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sr. Clerk	12b. KIND OF BUSINESS OR INDUSTRY Gas Transmission Corp.	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4 KINGS CT 21502
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM Y BRUNNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA DUNN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXX Yes War II		16b. SOCIAL SECURITY NO. 196-20-7527		17. INFORMANT Mrs. Billie J. Brunner, Cumberland, Md. Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) OAT CELL LUNG CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 1/2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Jan 9 1983, to JAN 8 1983, that (1) (we) last saw the deceased alive on Jan 9 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.					
22b. SIGNATURE So, MD		DEGREE		22c. DATE SIGNED 1/9/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) So		22e. ADDRESS 22 S GREENE ST. BALTO, MD. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 13, 1983	23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg Allegany Md	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR JAN 17 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



CHIEF

20%

CC



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 00756	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Irene		MIDDLE M. E.		LAST Buchsbaum		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 19	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11/16/1894		6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7b. DATE OF DEATH MONTH DAY YEAR 1 19 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3004 Virginia Avenue 21215	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3004 Virginia Ave. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Stahl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown to Records		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT 208 S. Kossuth St. Katherine Zenker Balto., MD 21229		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Hormez R. Guard, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 1/19/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery Baltimore City, Maryland				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, Catonsville, MD		25a. DATE RECEIVED BY REGISTRAR JAN 21 1983									



15

CONFIDENTIAL

CONFIDENTIAL



CONFIDENTIAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00757

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA BUNCH			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1983		2b. HOUR 12:40				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 2 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elm City, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home.		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 235 N. Dallas Ct. 21231		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Bunch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA Bunch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 245 20 6732		17. INFORMANT ADDRESS Orleanders T. Reid 611 George St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Italian Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Italian Carcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/82</u> to <u>1/5/83</u> , that (I) (we) last saw the deceased alive on <u>1/4/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>CLAUDE MORTON</u>			DEGREE no			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLAUDE MORTON			22e. ADDRESS Johns Hopkins Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/8/83		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.		
24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons 1701 Laurens Street					25a. DATE REC'D. BY REGISTRAR JAN 7 - 1983		25b. REGISTRAR'S SIGNATURE John J. Givish		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-333-3333.

RECEIVED  
MAY 10 1964  
U.S. AIR FORCE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C.

TO: THE SECRETARY, U.S. AIR FORCE  
FROM: THE SECRETARY, U.S. AIR FORCE  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 0 0 7 5 8					
1. FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
NOAH						BUNCH		1 27 83					3 20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
M		B		3 3 17		65		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
N. Carolina		U.S.A.				Baltimore City MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Provident Hospital													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2788 W. North Avenue 21216							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
N/A				N/A											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No				217-09-5121		Victoria Garris 2303 W. North Ave. Apt. 2									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Respiratory Arrest															
5070															
DUE TO, OR AS A CONSEQUENCE OF Pneumonia															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF Aspiration															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
Anil UBEROI															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
A. UBEROI															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL				1/31/83		Arbutus Mem. Pk.		Arbutus		COUNTY		MD.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE RECEIVED		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H Inc.				1101 E. North Avenue				JAN 31 1983		John J. Garris					

BP

Jan 31 1963  
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 0 0 7 5 9				
1. FOR REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET O'BRIEN BURCH					2a. DATE OF DEATH MONTH DAY YEAR 01- 10-83				2b. HOUR 5:30pm
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		8b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) school teacher		12b. KIND OF BUSINESS OR INDUSTRY education	
13a. STATE N. J.					13b. COUNTY		13c. CITY OR TOWN Sweedesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. O'Brien					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Reilly				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 146-30-4867		17. INFORMANT ADDRESS Ernest A. Burch Jr. 905 Breezewick Circle Towson, Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA COLON DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-28-82 to 01-10-83, that (I) (we) last saw the deceased alive on 01-10-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. F. Nazemi M.D. DEGREE 22c. DATE SIGNED 1/10/83						22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. F. NAZEMI M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 11, 1983		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION BALTIMORE CO., MD. STATE		
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hwy. Balto. Md.						25a. DATE REC'D. BY REGISTRAR JAN 12 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



*[Faint, mostly illegible text and markings on a lined document. Some visible fragments include:]*

*[Top right, near stamp:]* ...

*[Middle section:]* ...

*[Bottom section:]* ...

*[Bottom right, near circular stamp:]* ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 0 7 6 0			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Albert Burden</b>				2a. DATE OF DEATH		2b. HOUR	
FIRST		MIDDLE		MONTH DAY YEAR		10 <sup>37</sup> PM	
3. SEX <b>male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR. 15, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRESSMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>REISTERSTOWN</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS BURDEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		16. STREET ADDRESS <b>224 MYSTICWOOD RD. #21136</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-07-0265</b>		17. INFORMANT <b>HERMAN J. BURDEN</b> <b>224 MYSTICWOOD RD. REISTERSTOWN, MD 21136</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u></b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b><u>cerebrovascular Accident</u></b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>80</b> , to <b>1/1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. Pollet</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Claudia A Pollet</b>		22e. ADDRESS <b>22 South Green Street Balto</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHOMREI HADATH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25. DATE REC'D BY REGISTRAR OF REGISTRAR'S SIGNATURE <b>JAN 6 1983</b> <b>John J. Canale</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 00761			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN J. BURNS, JR.</b>				2a. DATE OF DEATH MONTH DAY YEAR 1-3-83 2:48 P.M.			
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR 5 20 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN; COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CITY GOVT.</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN J. BURNS, SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE SLEE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W.-II 213-14-4248</b>		17. INFORMANT ADDRESS <b>Mrs. Elizabeth Burns - 3017 Rosalie Ave. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPER OSMOLAR COMA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>36 hrs</b> <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>2502</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>82</b> , to <b>1/3</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/3</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. Kennedy MD.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		71c. DATE SIGNED <b>1/3/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER L. KENNEDY, M.D.</b>				22e. ADDRESS <b>GSH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-6-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Conner</b> ADDRESS <b>- 7527 Harford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM J. BURNS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 16 83</b>					2b. HOUR <b>6:55 P.M.</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 23, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE MFG.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>249 A RODGERS FORGE RD. 21212</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BURNS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDITH ACKERMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>152-07-2337</b>		17. INFORMANT ADDRESS <b>MARY K. R. CYPHERS 7004 KENLEIGH RD. 21212</b>						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <del>Extensive</del> <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 4 1/2 Hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Sepsis, Diabetes Mellitus, Chronic Renal Failure</b>										
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from <b>12/28/80</b> to <b>1/16/83</b> , that (I <input checked="" type="checkbox"/> saw the deceased alive on <b>1/16/83</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I <input type="checkbox"/> did not view the body after death.)										
22b. SIGNATURE <b>Bruce Allen Saap</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>Jan. 16, 1983</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Phillip Whittlesley</b>					22e. ADDRESS <b>600 W. Northern Parkway</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>		23b. DATE <b>JAN. 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OCEAN COUNTY MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>TOMS RIVER N.J.</b>				
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME</b>		BALTIMORE, MD.		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>		REGISTRAR'S SIGNATURE <b>John J. Connel</b>				



MEMORIAL

RIVERSIDE CITY

UNION MEMORIAL HOSPITAL

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MONIC BURRELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 25 1983</b>		2b. HOUR <b>09:30AM</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 81</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>1 YRS.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Darryl Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tia Burrell</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>N/A</b>				17. INFORMANT ADDRESS <b>Tia Burrell 1847 E. 29th Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4239</b> IMMEDIATE CAUSE (a) <b>loss of brainstem &amp; respiratory function</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiac tamponade</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
								<b>5 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>S/P VSD repair 11/83</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> , 19 <b>83</b> , to <b>1/25</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard D. Kayne MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard D. Kayne MD</b>				22e. ADDRESS <b>The Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>1/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glenburnie md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file them within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 6 4

REG. NO.

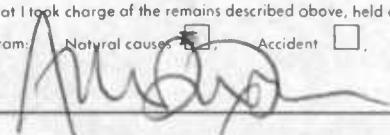

1. DECEASED NAME (TYPE OR PRINT) <b>PENROSE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 15 83</b>			2b. HOUR <b>2:00A M</b>			
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 2 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Baltimore, Maryland 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1116 W. Saratoga St. 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Burton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Butler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Arlene Cooper 5741 Jonquil Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2639 IMMEDIATE CAUSE (a) Cardiopulmonary aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INANITION</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ORCAUL BRAIN Syndrome</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 2, 1982</b> , to <b>January 15, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 15, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22a. SIGNATURE <b>George J. Magovern Jr.</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/15/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. AGOZKE</b>				22d. ADDRESS <b>VAMC, Baltimore, Maryland 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. J. Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

BP



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMAL PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                 |                                                                                                                                   |                                                             |  |                                                                                                                                                          |  |                                                                                              |                                                               | REG. NO. 000765                                                                                                            |                                   |                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WELDON BURTON Jr.                                                                                                                                                                                                                                                                                                                                                                |  |                 |                                                                                                                                   |                                                             |  |                                                                                                                                                          |  |                                                                                              |                                                               | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>1 22 1983 |                                   | 2b. HOUR<br>M                                                                       |  |
| 3 SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br>Black |                                                                                                                                   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 21 51                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>31                                                                                                               |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                    |                                                               | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 22 1983                                                                       |                                   | 2d. HOUR<br>12:32 P M                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                  |  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.    |                                                                                                                            |                                   |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |                                                             |  |                                                                                                                                                          |  |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 | 13b. COUNTY                                                                                                                       |                                                             |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                               | 13e. STREET ADDRESS<br>1525 N. Washington St 21213                                                                         |                                   |                                                                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Weldon Burden                                                                                                                                                                                                                                                                                                                                                                                   |  |                 |                                                                                                                                   |                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dorothy Hall                                                                                               |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                                   |  |                 |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>N/A                             |  | 17. INFORMANT ADDRESS<br>Richard Hance 1525 N. Washington St                                                                                             |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemoglobin SC disease</u><br><u>2826</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |                 |                                                                                                                                   |                                                             |  |                                                                                                                                                          |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                     |  |                 |                                                                                                                                   |                                                             |  |                                                                                                                                                          |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                                                                                                                                          |  |                                                                                              |                                                               |                                                                                                                            |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                 |                                                                                                                                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  |                 |                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                                                                                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                 |                                                                                                                                   |                                                             |  |                                                                                                                                                          |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                |  |                 |                                                                                                                                   |                                                             |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                       |  |                                                                                              |                                                               | DATE SIGNED<br>1-23-83                                                                                                     |                                   |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                  |  |                 |                                                                                                                                   |                                                             |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                                               |  |                                                                                              |                                                               |                                                                                                                            |                                   |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                    |  |                 |                                                                                                                                   | 23b. DATE<br>1/28/83                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Zion Cem.                                                                                                    |  |                                                                                              |                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md.                                                               |                                   |                                                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H Inc.                                                                                                                                                                                                                                                                                                                                                                                     |  |                 |                                                                                                                                   |                                                             |  | ADDRESS<br>1101 E. North Ave                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983                                                 |                                                               | 25b. REGISTRAR'S SIGNATURE<br>        |                                   |                                                                                     |  |

BR 546



## CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elder Benjamin A. Byrd                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 10 83                                                                                                              |                                                                                                 | 2b. HOUR<br>11:50 AM                                                           |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>Black                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 22 1897                                                                                                            |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                      |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |                                                                                |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                              |                                                                                                                              | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>21215 2851 Edgecombe Circle                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Byrd Sr.                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Primus                                                                                               |                                                                                                 |                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>349-16-1395                                                                                                                     |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>Howard Byrd 2851 Edgecombe Cir.                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myocardial Infarction</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>83</u> , to <u>1/10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                             |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                |
| 22b. SIGNATURE<br><u>M. Wellman</u>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br>1-10-83                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Maria Wellman                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              | 22e. ADDRESS<br>2600 Liberty Hgts                                                                                                                           |                                                                                                 |                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                           | 23b. DATE<br>1/15/83                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Burr Oaks Cem.                                                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Chicago Ill.                                      |                                                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. C. MARCH F.H.                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                              | ADDRESS<br>1101-E. North Ave.                                                                                                                               |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                              |                                                                                                                                                             |                                                                                                 | REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                                 |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (a), (b), or (c), the medical examiner must be notified at once.

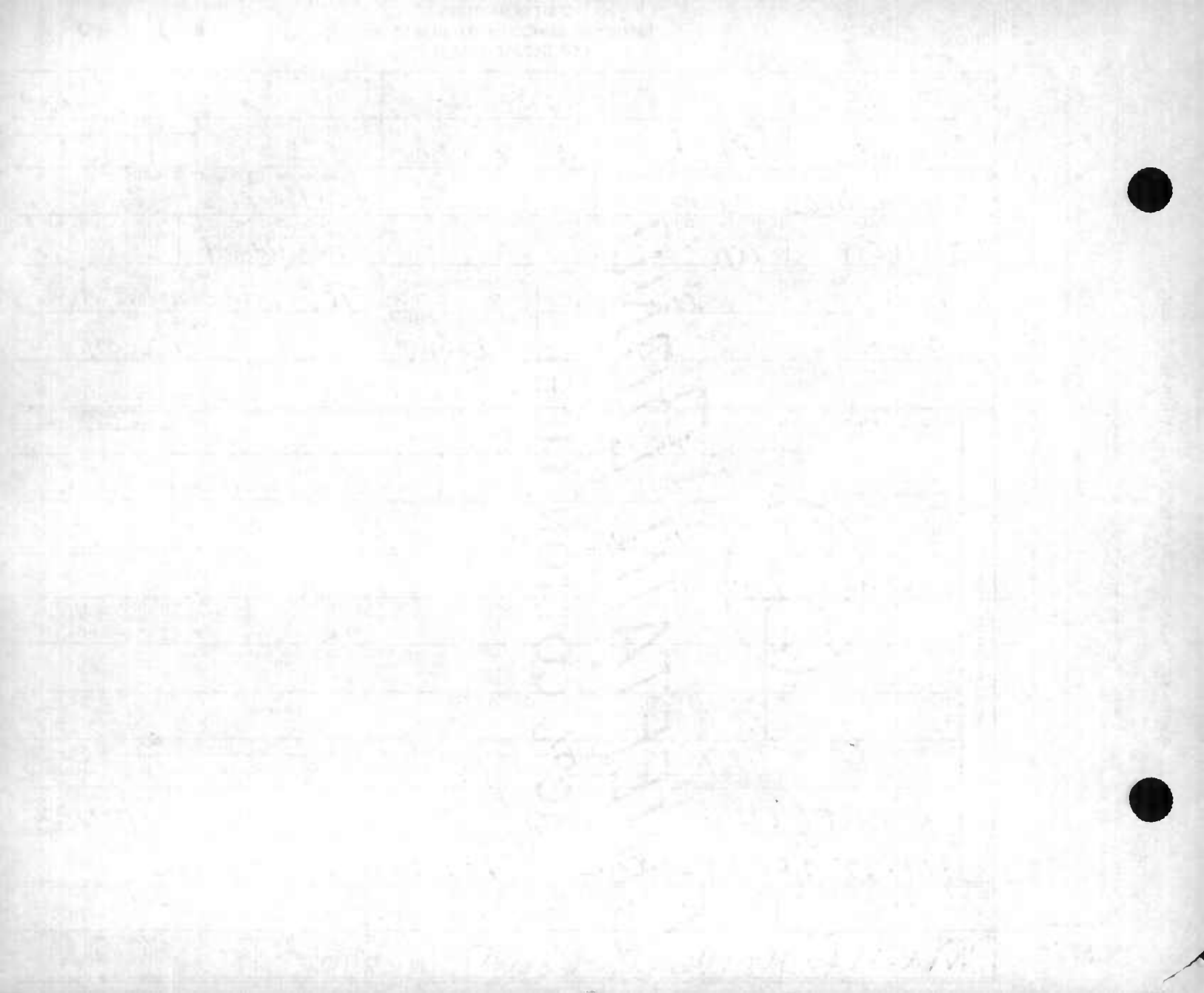
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                             |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jennie M. BYRD (Neely)</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>3:32 A</b>                                                                                                  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Black</b>                                                                                                     |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 30 30</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                  |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed.</b>                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                          |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                                       |                                                       | 13c. STREET ADDRESS<br><b>3006 Edmondson Ave</b>                                                                                                            |  | 21223                                                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IRVIN BYRD</b>                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ernest Powell</b>                                                       |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>231-36-5742</b>                                               |                                                       | 17. INFORMANT ADDRESS<br><b>Amos Neely 3006 Edmondson Avenue</b>                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4589</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION (Reelal carcinoma)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BRADYCARDIA, (Fatty liver severe)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                             |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CEREBRAL ANOXIA.</b>                                                                                                                                                                                                                          |  |                                                                                                                             |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |                                                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19 83</b>                                                             |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> , 19 <b>83</b> , to <b>1/23</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/23</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                  |  |                                                                                                                             |                                                       |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Robert Artwohl M.D.</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |                                                       | DEGREE<br><b>M.D.</b>                                                                                                                                       |  | 22c. DATE SIGNED<br><b>1/23/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Ray Artwohl</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |                                                       | 22e. ADDRESS<br><b>Bon Secours Hospital</b>                                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>1/28/83</b>                                                                                                 |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Home 101 E. North</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                             |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                         |  |                                                                                                                            |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 6 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | FIRST<br>RONALD                                                                                                                                             | MIDDLE<br>B.                                                                   | LAST<br>CALDER                                                                                                                                       | 2a. DATE OF DEATH                                                                               |                                                                             | MONTH<br>1                                            | DAY<br>4                                                                                                                   | YEAR<br>83       | 2b. HOUR<br>945 A.M.                         |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br>White                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 25, 1917                                                                                                        |                                                                                |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65                                                           |                                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |                                                                                                                            | IF UNDER 24 HRS. |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                                                                                                             |                                                                                |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>R.R. Western Md.            |                                                                             |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                  |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 13b. COUNTY<br>---                                                                                                                                          | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                             | 13e. STREET ADDRESS<br>1803 Belt St. Balto. Md. 21230 |                                                                                                                            |                  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Phillip --- Calder                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie --- Lank               |                                                                                                                                                      |                                                                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |                                                       |                                                                                                                            |                  |                                              |  |
| 16b. SOCIAL SECURITY NO.<br>035-22-7864                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>V. Carpenter, & Mrs. Edna G. Calder, Same as above |                                                                                                                                                      |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>UPPER GI bleed.</u><br><u>4599</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Necrotic Jejunum.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Vascular Deter. Occlusion - Diabetes.</u> |                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Renal Failure</u>                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                |                                                                                                                                                      |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                         |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1. 3</u> , 19 <u>83</u> , to <u>1. 4</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1. 4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                        |                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 22b. SIGNATURE<br><u>Anna Ferrari</u>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                             |                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 |                                                                             |                                                       | 22c. DATE SIGNED<br>1. 4. 83.                                                                                              |                  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANNA FERRARI                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                                                                                                              |                                                                                                 |                                                                             |                                                       |                                                                                                                            |                  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 23b. DATE<br>Jan. 7, 1983                                                                                                                                   |                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>North Road Cemetery                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN<br>Campobello,                                |                                                       | COUNTY<br>Canada                                                                                                           |                  | STATE                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983                                                                                                          |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                |                                                       |                                                                                                                            |                  |                                              |  |



Handwritten signature or text at the bottom left.

Handwritten text, possibly a date or reference number.

Handwritten text at the bottom right, possibly a name or title.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | REG. NO. 83 00769                                                                                                                 |  |                                                                                                                                                             |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary G. Caldwell                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 19 83               |                                                                        |                                              | 2b. HOUR<br>6:30 PM                                                                                                     |                                                                                                                                 |  |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>white                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3/28/1908                                                                                                                |                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                             |                                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |                                                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>York, PA.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.            |                                              |                                                                                                                         |                                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |                                                                                                                                                             |                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk |                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>Drug Store                                                                         |                                                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                  |                                                                        | 13c. CITY OR TOWN<br>City                    |                                                                                                                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank Appold                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edna Lamont |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>215-16-1952A                                                                                          |  | 17. INFORMANT ADDRESS<br>21206 (daughter) 5529 Bucknell Rd.                                                                                                 |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>5789<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Upper Gastrointestinal tract bleed</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Prior Pyloric Channel bleed</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 minutes</u><br><u>8 days</u><br><u>62 days</u> |  |                                                                                                                                   |  |                                                                                                                                                             |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Respiratory Infection, Renal Infection, Hepatic Infection</u>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 19a. DATE OF OPERATION<br>1/11/83                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pyloric Channel bleed                                                         |  |                                                                                                                                                             |                                                           | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>82</u> to <u>1/17</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                             |                                                           |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 22b. SIGNATURE<br>Robert Udelsman MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             | DEGREE                                                    |                                                                        | 22c. DATE SIGNED<br>1/19/83                  |                                                                                                                         | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Udelsman MD                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                             | 22e. ADDRESS<br>Baltimore City Hospital                   |                                                                        |                                              |                                                                                                                         |                                                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>1/22/83                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                                                                                                    |                                                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City MD.          |                                              |                                                                                                                         |                                                                                                                                 |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Schimunek Funeral Home 3331 Brehms Ln.                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1983              |                                                                        | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Carney |                                                                                                                         |                                                                                                                                 |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

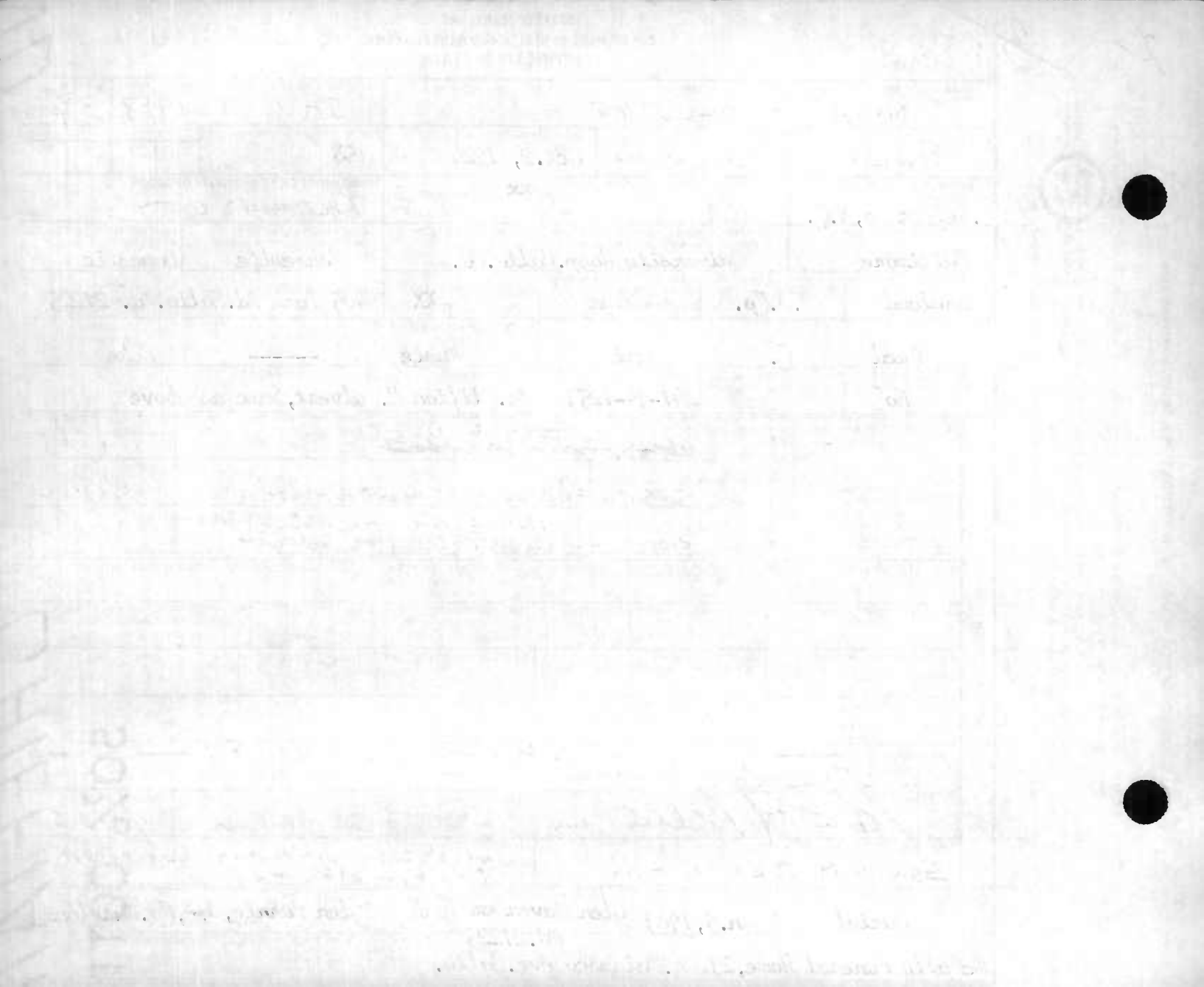
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | 8 3 0 0 7 7 0                                                                                                                                               |  |                                                                                                                         |                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                                                    |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>NINA F CALVERT                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>JAN. 1 1983 330 P.M.                                                                                           |  |                                                                                                                         |                                                                    |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Caucasian                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 2, 1924                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>58 YRS.                                                       |                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee, N.C.                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                              |                                                                    |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hosp. Balto. Md. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife,                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic                                                                           |                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 13a. STREET ADDRESS                                                                                                                                         |  |                                                                                                                         |                                                                    |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>A.A. Co.                                                                                                               |  | 13c. CITY OR TOWN<br>Brooklyn                                                                                                                               |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                                                    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Fred C. Hart                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Musie ----- Duke                                                                                              |  |                                                                                                                         |                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>241-34-1253                                                                                               |  | 17. INFORMANT ADDRESS<br>Mr. Clifton H. Calvert, Same as above                                                                                              |  |                                                                                                                         |                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>4301 IMMEDIATE CAUSE (a) <del>CARDIOPHRYNEMIC ANEURISM</del><br>DUE TO, OR AS A CONSEQUENCE OF (b) SUBARACHNOID HEMORRHAGE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF INTRACRANIAL ANEURYSM - RIGHT ANTERIOR CEREBRAL ARTERY |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1/1/83<br>12/23/82 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         |                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                                                    |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/82, 19, to 1/1/83, 19, that (I) (we) lost saw the deceased alive on 1/1/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         |                                                                    |
| 22b. SIGNATURE <i>Edwin H. Bellis</i> DEGREE                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/1/83                                                                                              |                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWIN H. BELLIS M.D.                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HEALTH CENTER<br>BALTIMORE, MD.                                                                                      |  |                                                                                                                         |                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>Jan. 5, 1983                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Park<br>Md. 21225                                                                                      |  | 23d. LOCATION<br>Glen Burnie, A, A, Co. Maryland                                                                        |                                                                    |
| 24. FUNERAL DIRECTOR<br>McCully Funeral Home, 237 E. Patapsco Ave. Balto.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>                                                                     |                                                                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 7 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     |                                               |                                                                |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | 2a. DATE OF DEATH                                             |                                                                               |                                                                     | 2b. HOUR                                      |                                                                |                                              |
| Mildred Elizabeth Canby                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          | January 11, 1983                                              |                                                                               |                                                                     | 4:30p M                                       |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                                                                               |                                                                     | 7. IF UNDER 1 YEAR                            |                                                                |                                              |
| Female                                                                                                                                                                                                                                                                                                                                                                    | White                                                                                                  | 6-14-1907                                                                                                                                                | 75 YRS.                                                       |                                                                               |                                                                     | MONTHS DAYS HOURS MIN.                        |                                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                               |                                                                     |                                               |                                                                |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                  | USA                                                                                                    |                                                                                                                                                          | Baltimore City MD.                                            |                                                                               |                                                                     |                                               |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                               |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY             |                                                                |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                 | Maryland General Hospital                                                                              |                                                                                                                                                          | Housewife                                                     |                                                                               |                                                                     | Household                                     |                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | 13b. COUNTY                                                   |                                                                               |                                                                     | 13c. CITY OR TOWN                             |                                                                |                                              |
| Md.                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | Baltimore                                                     |                                                                               |                                                                     | Serern                                        |                                                                |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                      |                                                                               |                                                                     | 16. SOCIAL SECURITY NO.                       |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          | FIRST MIDDLE LAST                                             |                                                                               |                                                                     | 17. INFORMANT ADDRESS                         |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                      |                                                                               |                                                                     | 17. INFORMANT ADDRESS                         |                                                                |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | 819-16-7717                                                   |                                                                               |                                                                     | Daisy B. Elliott Same as 13                   |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hystiocytic Lymphoma</u><br>2000<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     |                                               |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Status Post Small Bowel Perforation</u>                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     |                                               |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               |                                                                               | 20a. AUTOPSY?                                                       |                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                     |                                               |                                                                |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                 |                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                     |                                               |                                                                |                                              |
| 22a. I certify that (this hospital) attended the deceased from <u>December 22</u> , 19 <u>82</u> , to <u>January 11</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>January 11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     |                                               |                                                                |                                              |
| 22b. SIGNATURE<br><u>Richard A. Lane</u> MD                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     | 22c. DATE SIGNED<br>1/12/83                   |                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard A. Lane, M.D.                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               |                                                                               |                                                                     | 22e. ADDRESS<br>c/o Maryland General Hospital |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE    |                                                                |                                              |
| Cremation                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 1-12-83                                                                                                                                                  |                                                               | Westview Crematory                                                            |                                                                     | Balt. Balt. Md.                               |                                                                |                                              |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                 |                                                                     | 25b. REGISTRAR'S SIGNATURE                    |                                                                |                                              |
| Hardesty Funeral Home                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                               | AN 13 1983                                                                    |                                                                     | John J. Caner                                 |                                                                |                                              |

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 / 7 2

REG. NO.

|                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                     |  |                |               |                                                                  |                        |                                       |  |                                       |  |
|-----------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------|---------------|------------------------------------------------------------------|------------------------|---------------------------------------|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James</b>                                        |  | FIRST <b>Capers</b>                                                                                                                         |  | MIDDLE <b>Sr.</b>                                                                                                                                           |  | LAST                                                                                            |  | 2a. DATE OF DEATH                                                   |  | MONTH <b>1</b> | DAY <b>30</b> | YEAR <b>83</b>                                                   | 2b. HOUR <b>1 p.m.</b> |                                       |  |                                       |  |
| 3. SEX <b>M</b>                                                                         |  | 4. RACE <b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH                                                                                                                                            |  | MONTH <b>12</b>                                                                                 |  | DAY <b>03</b>                                                       |  | YEAR <b>07</b> |               | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>                        |                        | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> |  | IF UNDER 24 HRS.<br>HOURS <b>MIN.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD                                   |  |                                                                     |  |                |               |                                                                  |                        |                                       |  |                                       |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Deaton Medical Center</b> |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                     |  |                |               |                                                                  |                        |                                       |  |                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                     |  |                |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                        | 12b. KIND OF BUSINESS OR INDUSTRY     |  |                                       |  |
| 13a. STATE <b>Md.</b>                                                                   |  | 13b. COUNTY <b>Balto.</b>                                                                                                                   |  | 13c. CITY OR TOWN <b>Balto.</b>                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1945 Fayette St. 21223</b>                   |  |                |               |                                                                  |                        |                                       |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST <b>Willie</b> MIDDLE <b>Capers</b> LAST <b>Capers</b>        |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosie</b> MIDDLE <b>Capers</b> LAST <b>Capers</b>                                                                      |  |                                                                                                 |  |                                                                     |  |                |               |                                                                  |                        |                                       |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>          |  |                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  |                                                                                                 |  | 17. INFORMANT ADDRESS<br><b>Rosie Lee Tatum 1945 Fayette St. 23</b> |  |                |               |                                                                  |                        |                                       |  |                                       |  |

|                                                                                                                                                               |  |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.                     |  | (b) <b>Squamous Cell Carcinoma of Lung</b> / yr |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                         |  |                                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Robert A. Banthe</b>                                                                                                                                                                                                                                                                                         |  | DEGREE <b>MD</b>                                                       |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/31/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Banthe</b>                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>611 S. Charles Street Baltimore Md.</b>             |  |                                                                                                                                            |  |                                                                                                                               |  |

|                                                                                        |  |                         |  |                                                           |  |                                                                         |  |
|----------------------------------------------------------------------------------------|--|-------------------------|--|-----------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                             |  | 23b. DATE <b>2/3/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn Md. A A C</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Charles A. Rice FSPA</b> ADDRESS <b>1300 Eutaw Pl.</b> |  |                         |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300173

1. FOR  
STATE  
REGISTRAR

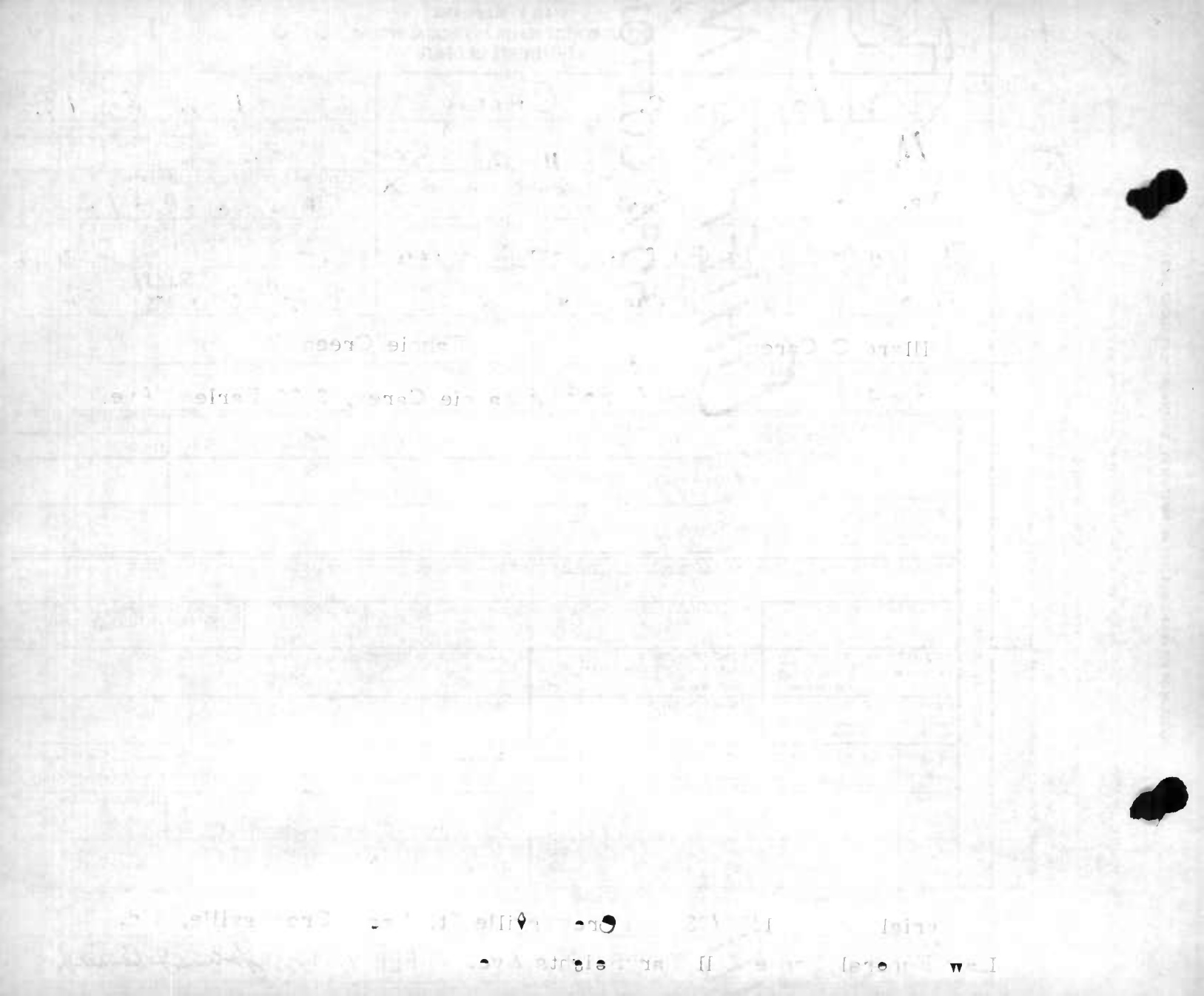
REG. NO.

|                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |  |                                                                   |                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willard C. Carey</b>                                                                                                                     |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-20-83</b>                                              |  |                                                                   | 2b. HOUR<br><b>1 P.M.</b> |  |
| 3. SEX<br><b>M</b>                                                                                                                                                              | 4. RACE<br><b>B</b>                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11-21-50</b>                                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>32</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City - MD.</b>                             |  |                                                                   |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp. &amp; Md.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-empl</b>             |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>USA</b> 13c. CITY OR TOWN <b>Baltimore</b> |                                                                                                                                              |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2121 1016 Woodward St.</b>              |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willard C Carey</b>                                                                                                                |                                                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Green</b>                            |  |                                                                   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                                                                                                 |                                                                                                                                              |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>216-546-886</b>                                                  |  | 17. INFORMANT<br>ADDRESS<br><b>Fannie Carey, 3029 Harlem Ave.</b> |                           |  |

|                                                                                                                                                                   |  |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive G.I. bleeding 2:0</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| (b) <b>Esophageal Varices</b>                                                                                                                                     |  |                                                 |
| (c) <b>Extensive Portal Cirrhosis</b>                                                                                                                             |  |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                               |  |                                                 |

|                                                                                                                                                                                                                                                                                                                                      |  |                                                                                       |  |                                                                                |  |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><b>1-20-83</b>                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Massive bleeding</b>           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N.A.</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-19-83</b> , to <b>1-20-83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-20-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                       |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Jogendra Singh, MD</b>                                                                                                                                                                                                                                                                                          |  |                                                                                       |  | DEGREE<br><b>MD</b>                                                            |  | 22c. DATE SIGNED                                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOGENDRA SINGH</b>                                                                                                                                                                                                                                                                       |  |                                                                                       |  | 22e. ADDRESS<br><b>1190 W. NORTHERN PKwy</b>                                   |  |                                                                                                                               |  |

|                                                                                |  |                             |  |                                                                  |  |                                                                       |  |
|--------------------------------------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                  |  | 23b. DATE<br><b>1/26/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville St. Vaa</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1983</b>               |  |                                                                       |  |
|                                                                                |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>              |  |                                                                       |  |

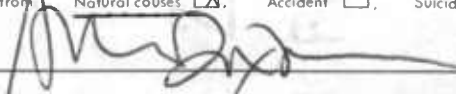



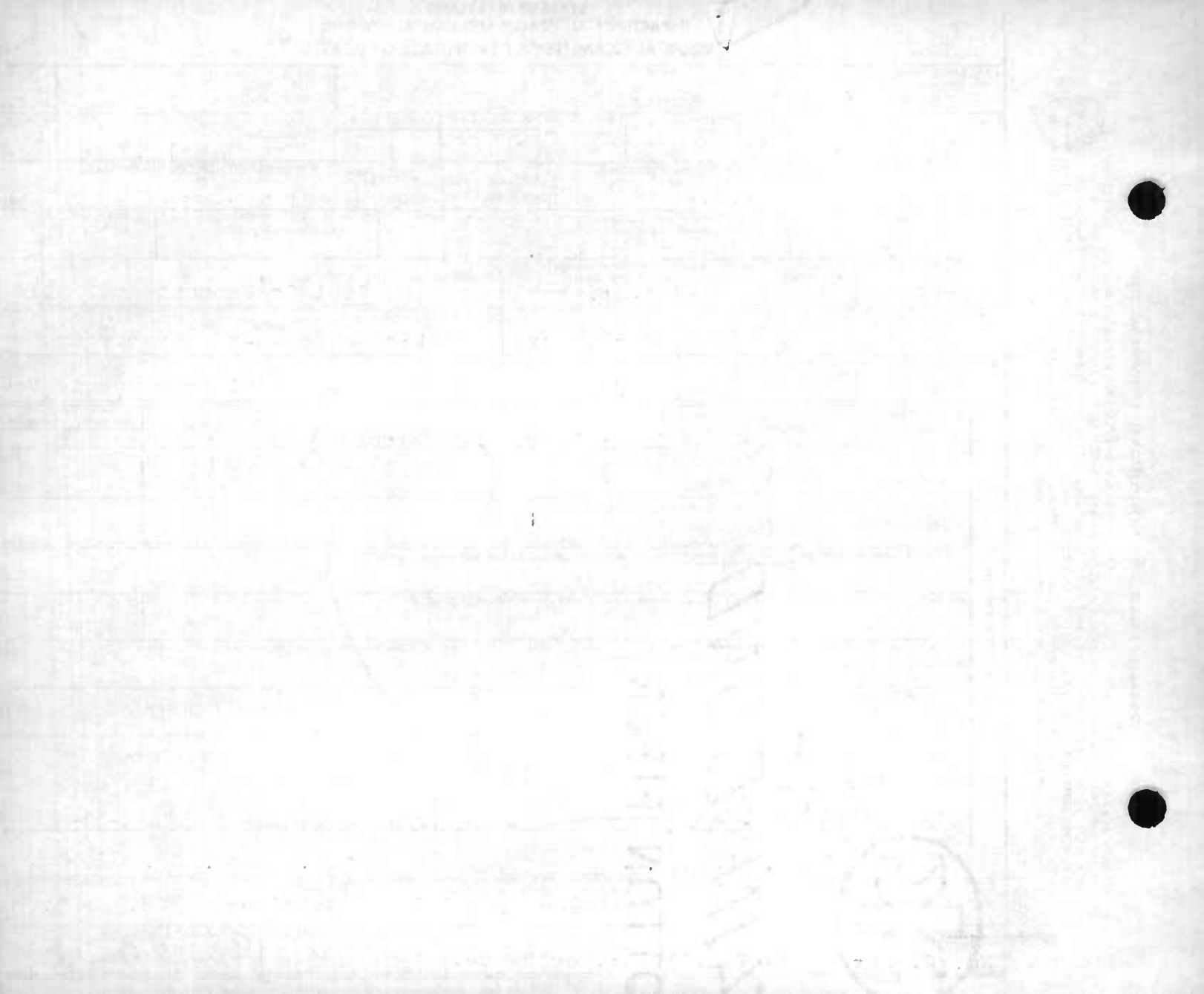


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | REG. NO. 8 3 0 0 7 7 4                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | 20. DATE KNOWN OF DEATH                                                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Dante (DONTE) Leumel CARR</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | 21. DATE KNOWN OF DEATH <b>1 22 1983</b>                                                                         |  |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH <b>11 4 82</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>2 17</b>                                   |  | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                                                                                               |  | 22. DATE PRONOUNCED DEAD <b>1 22 1983</b>                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                |  |                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                                       |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hosp. (DOA)</b> |  |                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | 13b. CITY OR TOWN <b>Baltimore</b>                                                                               |  |
| 14. FATHER'S NAME <b>Leumel Carr, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME <b>Bobbie Kennedy Armstrong</b>                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                             |  |                      |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>                                                                                                       |  |                                                                               |  | 17. INFORMANT ADDRESS <b>Bobbie Kennedy 2601 Greenmount Ave.</b>                                                                                         |  |                                                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>7990 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                  |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  |                                                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                         |  |                                                                               |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                                                          |  |                                                                                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |                                                                                                                                                          |  |                                                                                                                  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion. |  |                      |  |                                                                                                                                           |  |                                                                               |  |                                                                                                                                                          |  |                                                                                                                  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                      |  |                      |  | TITLE (SPECIFY) M.D. Assistant                                                                                                            |  |                                                                               |  | DATE SIGNED 1-22-83                                                                                                                                      |  |                                                                                                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                                                                            |  |                                                                               |  |                                                                                                                                                          |  |                                                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                      |  | 23b. DATE <b>1/27/83</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Memorial Pk</b>                |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. PR.</b>                                                 |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  |                                                                                                                                           |  | ADDRESS <b>1101 E. North Ave.</b>                                             |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

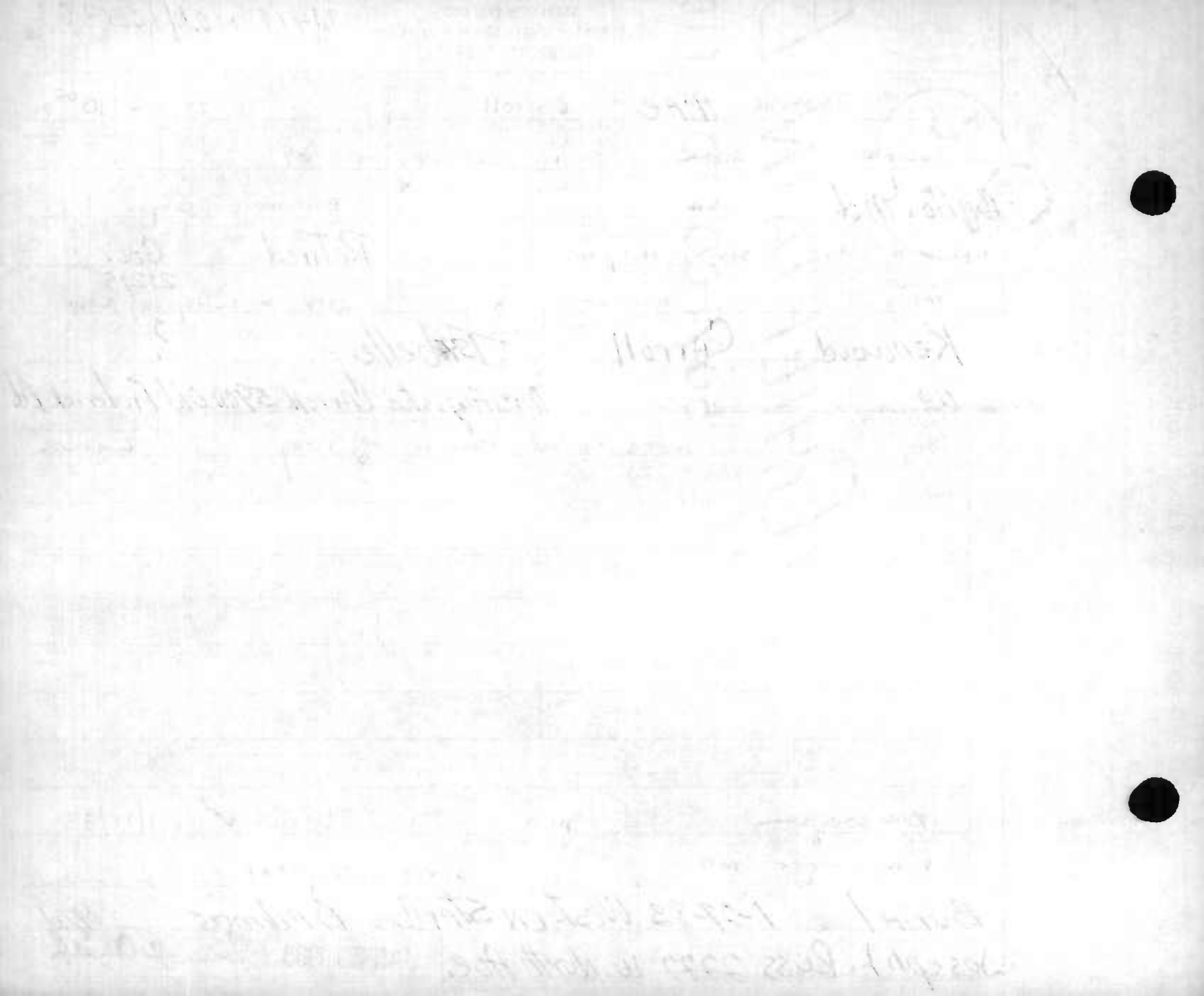
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |                                                                                                 | REG. NO.                                                                                                                   |                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Isabelle MAE Carroll                                                                                                                                                                                                                                                                                                                                            |                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 23 83                                                  |                                                                                                                            | 2b. HOUR<br>10 <sup>05</sup> P.M.                               |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>Black                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 20 14                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                                       |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| BIRTHPLACE<br>BALTO. MD.                                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                      |                                                                                                                            |                                                                 |
| OR TOWN OF DEATH<br>Baltimore city                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sina Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                                 |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov.                                                                                  |                                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                                                                            | 13b. COUNTY<br>BALTIMORE                                                                                                   | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>21215 2914 W. Coldspring Lane                                                                       |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kennard Carroll                                                                                                                                                                                                                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>Isabelle                                                                                       |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                         |                                                                                                                            |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                                                                                   | 17. INFORMANT<br>Mrs Augustus Carroll 5900 Old Frederick Rd.                                                                                                |                                                                                                 |                                                                                                                            |                                                                 |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) metastatic Adenoc of lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years |                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)                                                                                                                                                                                                                                                                   |                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                 |                                                                                                                            |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                                                                            |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                      |                                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                                 |
| 22b. SIGNATURE<br>R.M. Cooper MD                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            | DEGREE<br>MD                                                                                                                                                |                                                                                                 | 22c. DATE SIGNED<br>1/23/83                                                                                                |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R.M. Cooper MD                                                                                                                                                                                                                                                                                                                                                |                                                                                                                            | 22e. ADDRESS<br>Sina Hospital                                                                                                                               |                                                                                                 |                                                                                                                            |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial                                                                                                                                                                                                                                                                                                                                                    | 23b. DATE<br>1-27-83                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Star Cem                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                                      |                                                                                                                            |                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ 2222 W. North Ave.                                                                                                                                                                                                                                                                                                                                      |                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983                                                                                                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                               |                                                                 |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                      |                                                                                             |                                                                                                                                                          |                                                                                                     |                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joshua Nolan Carroll</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                      | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 8 19 83</b> |                                                                                                                                                          |                                                                                                     | 2b. HOUR <b>7:28</b> M <b>P</b>                                   |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 3, 1915</b>                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                           | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                    | 7c. DATE PRONOUNCED DEAD <b>1 8 19 83</b>                                                           |                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6312 Marietta 6312</b> |                                                                                             |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Self Employed Fuel Oil</b> |                                                                   |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 13b. COUNTY                                                                                                                          | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                       | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS<br><b>6312 Marietta Ave. 21214</b>                                              |                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Lester N. Carroll</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Catherine E. Sader</b>                     |                                                                                                                                                          |                                                                                                     |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | 16b. SOCIAL SECURITY NO.<br><b>213-36-9559</b>                                                                                       |                                                                                             | 17. INFORMANT ADDRESS<br><b>Lester J. Carroll, 3318 Bayonne Ave. 21214</b>                                                                               |                                                                                                     |                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |                         |                                                                                                                                      |                                                                                             |                                                                                                                                                          |                                                                                                     |                                                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                      |                                                                                             |                                                                                                                                                          |                                                                                                     |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                    |                                                                                             |                                                                                                                                                          | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                                                                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                     |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 PART 1 OR PART 2)                                                                            |                                                                                                     |                                                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                          |                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                                                     |                                                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                      |                                                                                             |                                                                                                                                                          |                                                                                                     |                                                                   |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                                                                                             |                                                                                             |                                                                                                                                                          | DATE SIGNED <b>1/9/83</b>                                                                           |                                                                   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                         | ADDRESS<br><b>111 Penn St., Balto., Md.</b>                                                                                          |                                                                                             |                                                                                                                                                          |                                                                                                     |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 23b. DATE<br><b>1-12-83</b>                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland</b>                                       |                                                                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                    |                                                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                      |                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>                                                                                                      |                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>               |



Aug. 1, 1917

Notice

Notice

Mr. J. H. ...

1917

Notice

Notice

Notice

Notice

1917-1918

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 0 7 7 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                           |                                   |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ann E. Carson                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 27 83 |                                                                                                                                                             |  | 2b. HOUR<br>M                                                                                                                                   |  |                                                                           |                                   |                                                                                                                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                                |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 12 15                                                                                                               |  | 6. AGE, (IN YEARS LAST BIRTHDAY)<br>67 YRS                                                                                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                         |                                   | 8. IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                      |  |                                                                           |                                   |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                   |  |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                                                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                |                                                                                                                                                             |  | 13b. COUNTY                                                                                                                                     |  | 13c. CITY OR TOWN<br>Balto.                                               |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |                                                |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma A. Watts                                                                                  |  |                                                                           |                                   |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-30-0923                                                                                      |  | 17. INFORMANT<br>2834 Southview Rd., Ellicott City Md. 21043<br>Mrs. Faye Becraft                                                               |  |                                                                           |                                   |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cadac Arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                     |  |                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                           |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                              |  |                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                           |                                   |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  |                                                                                                                                 |                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                               |  |                                                                           |                                   |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                               |  |                                                                           |                                   |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1/80</u> to <u>January 23, 1983</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>83</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                           |                                   |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>Patrick W. White</u><br>DEGREE M.D.<br>22c. DATE SIGNED                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                |                                                                                                                                                             |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                           |                                   |                                                                                                                               |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Patrick W. White</u>                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |                                                |                                                                                                                                                             |  | 22f. ADDRESS                                                                                                                                    |  |                                                                           |                                   |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                | 23b. DATE<br>1-31-83                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD.                  |                                   | 23e. DATE REC'D. BY REGISTRAR<br>FEB 2 1983                                                                                   |  |
| 24. FUNERAL DIRECTOR<br>G. TRUMAN SCHWAB<br>3512 FREDERICK AVE.<br># 21229                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                                |                                                                                                                                                             |  | 25. REGISTRAR'S SIGNATURE<br>John J. Cahill                                                                                                     |  |                                                                           |                                   |                                                                                                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





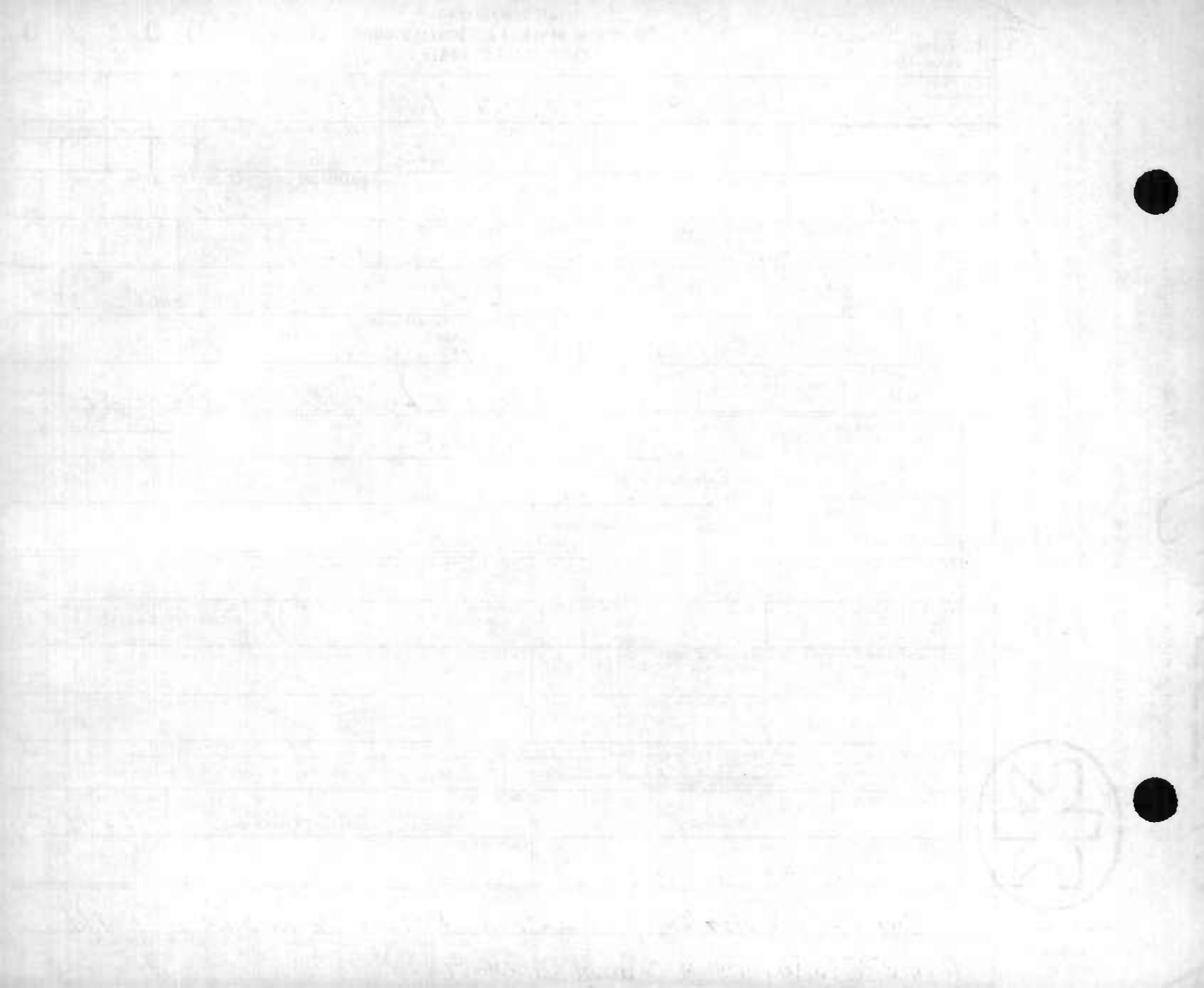
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                                 |  | 8 3 0 0 7 7 8<br>REG. NO.                                                                                                  |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CARWELL DOROTHY A.</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/24/83</b>                                                                                                       |  |                                                                                                 |  | 2b. HOUR<br><b>10:00 a.m.</b>                                                                                              |  |                                              |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>B</b>                                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 19 14</b>                                                                                                        |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>68</b> YRS.                                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD                                          |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMPLOYED</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                              |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                                         |  | 13c. CITY OR TOWN<br><b>BALTIMORE CITY</b>                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>520 N BRICE ST</b>                                                                               |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH R BOOKER</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE MITCHELL</b>                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>Donald A. Carwell 500 BRICE ST. 21217</b>                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1479</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DISSEMINATED NASOPHARYNGEAL CANCER</b> |  |                                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/83</b> , 19____, to <b>1/24/83</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/24/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                   |  |                                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><b>J. Hornedo</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>1/24/83</b>                                                                                         |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. HORNEDO</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>1/25/83</b>                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CROWNVILLE NAT'L</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownville Md</b>                              |  |                                                                                                                            |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>VERNON B. Bailey 1348 N. Calhoun St. 21217</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                             |  |                                                                                                                            |  |                                              |  |

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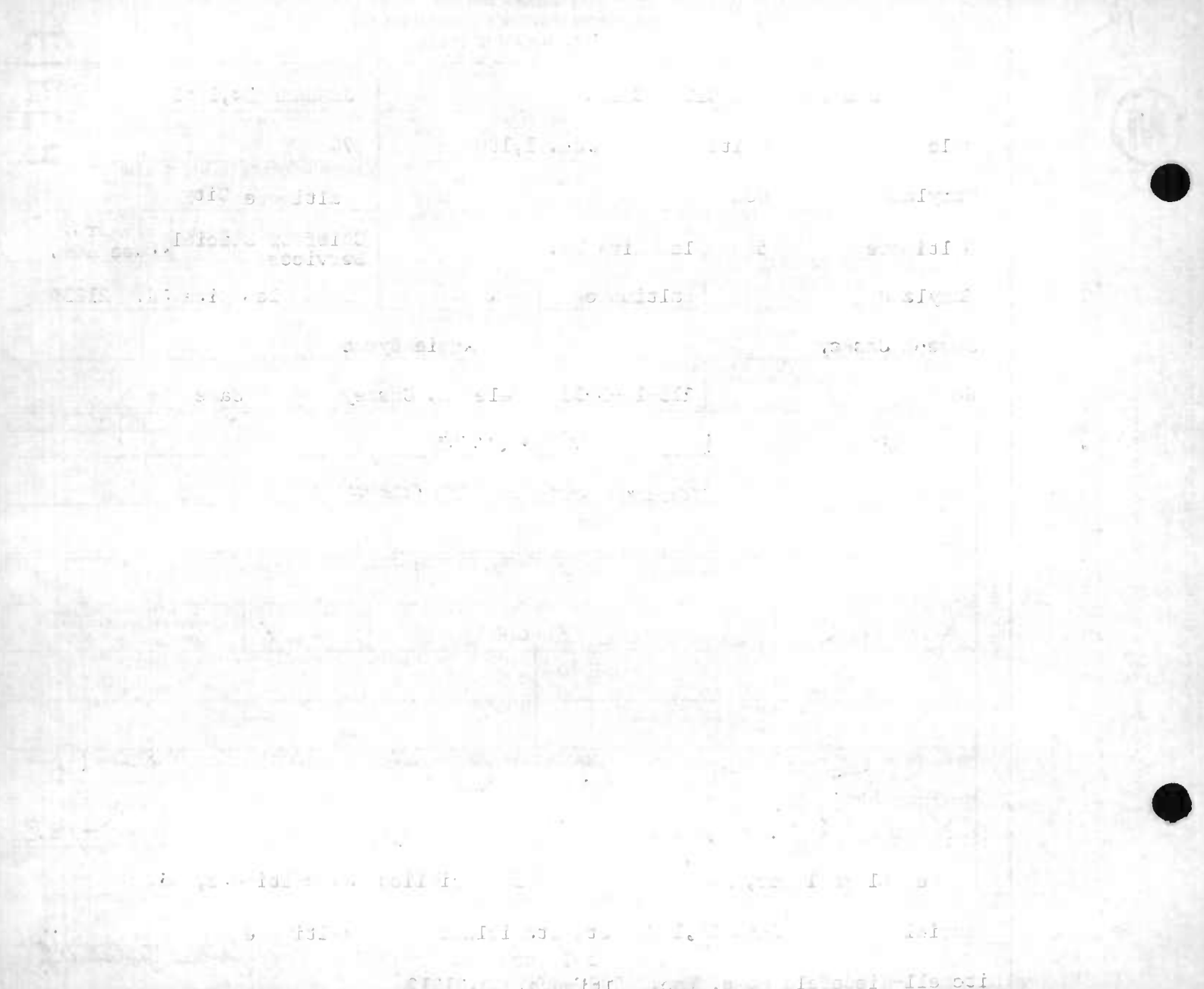


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  | 8 3 0 0 / 7 9                                                                                                                                               |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOSEPH FRANCIS CASKEY                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 24, 1983                                                                                                        |  | 2b. HOUR<br>8 <sup>30</sup> A.M.                                                                                           |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>White                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 1, 1909                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5946 Glen Kirk Rd. |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Chief of Special Services                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Drug Abuse Adm.                                                                       |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Caskey                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Byrne                                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>215-10-3035                                                          |  | 17. INFORMANT<br>Helen A. Caskey                                                                                                                            |  | 17. ADDRESS<br>Same                                                                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Lung metastases</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE<br>_____ |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>_____                                                                                                                                                                                                                                          |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>Aug 1982                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Esophageal cancer                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>_____                                                                     |  |                                                                                                                            |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____                                                                                                                                                                                                                                                                                                         |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>_____                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>January 1983</u> to <u>1/24</u> 19 <u>83</u> , that (1) (we) lost <u>1/24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Kendall R Faulkner MD                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                              |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/24/83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kendal Faulkner, M.D.                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  | 22e. ADDRESS<br>5606 Pimlico Rd. Baltimore, Md.                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>Jan. 27, 1983                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus                                                                                                        |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc. Baltimore, Md. 21212                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 31 1983                                                                                                              |  |                                                                                                                            |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 8 0

REG. NO.

|                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------|--|---------------------|--|-------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                       |  | 2a. DATE OF DEATH                                                                                                                                           |  | MONTH                                                               |  | DAY                        |  | YEAR                |  | 2b. HOUR                                        |  |
|                                                                                                                                                                                                                                                                                                              |  | NELLIE MAY MARY CASSERLY                                                                                  |  | 1                                                                                                                                                           |  | 31                                                                  |  | 83                         |  | 12 <sup>35</sup>    |  | A <sup>M</sup>                                  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS     |  |                                                 |  |
| FEMALE                                                                                                                                                                                                                                                                                                       |  | WHITE                                                                                                     |  | MONTH DAY YEAR<br>03 25 22                                                                                                                                  |  | 60 YRS                                                              |  | MONTHS DAYS                |  | HOURS MIN.          |  |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |  |                     |  |                                                 |  |
| MARYLAND                                                                                                                                                                                                                                                                                                     |  | U.S.A.                                                                                                    |  |                                                                                                                                                             |  | BALTIMORE CITY                                                      |  |                            |  |                     |  | MD.                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                            |  |                     |  |                                                 |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                    |  | UNION MEMORIAL HOSPITAL                                                                                   |  | SECRETARY                                                                                                                                                   |  | RECORDS &                                                           |  |                            |  |                     |  |                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS        |  | TAPES               |  |                                                 |  |
| MARYLAND                                                                                                                                                                                                                                                                                                     |  | A.A.                                                                                                      |  | CLEARWATER BEACH                                                                                                                                            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 8109 HIGHPOINT ROAD, 21226 |  |                     |  |                                                 |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT              |  | ADDRESS             |  |                                                 |  |
| THOMAS                                                                                                                                                                                                                                                                                                       |  | BESSIE                                                                                                    |  | NO                                                                                                                                                          |  | 213-18-7618                                                         |  | MARK A. CASSERLY           |  | 8109 HIGHPOINT ROAD |  | 21226                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4240 IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Valvular Heart Disease                 |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  |                                                 |  |
| Aortic stenosis, Mitral regurgitation, chronic CHF                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |                            |  |                     |  |                                                 |  |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |                     |  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                                                                              |  |                                                                     |  |                            |  |                     |  |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET                                                                                                                                     |  | CITY OR TOWN                                                        |  | COUNTY                     |  | STATE               |  |                                                 |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/30, 1983, to 1/31, 1983, that (1) (we) last saw the deceased alive on 1/31, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  |                                                 |  |
| 22b. SIGNATURE<br>D M Riffey                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/31/83                                         |  |                            |  |                     |  |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M. Riffey                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br>Union Memorial Hospital                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                            |  |                     |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                     |  | STATE               |  |                                                 |  |
| BURIAL                                                                                                                                                                                                                                                                                                       |  | 02-03-83                                                                                                  |  | MEADOWRIDGE MEM. PK.                                                                                                                                        |  | ELK RIDGE                                                           |  | HOWARD                     |  | MARYLAND            |  |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                 |  | 24b. ADDRESS                                                                                              |  | 25a. DATE OF DEATH                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                            |  |                     |  |                                                 |  |
| HUBBARD FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                   |  | 4107 WILKENS AVE.                                                                                         |  | 21229                                                                                                                                                       |  | FEB 2 1983                                                          |  |                            |  |                     |  |                                                 |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the bottom left, possibly a signature or date: "Feb 2 1903" and "J. L. Smith".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 8 3 0 0 7 8 1                                                                                                                                               |  |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Willie D. Canada</i>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 2a. DATE OF DEATH<br>MONTH <i>1</i> DAY <i>21</i> YEAR <i>83</i> 2b. HOUR <i>10:50 A.M.</i>                                                                 |  |                                                                                                                            |                                              |
| 3 SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><i>Negro</i>                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH <i>7</i> DAY <i>1</i> YEAR <i>1913</i>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD.</i>                                                         |                                              |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lafayette Square Nsg. Center</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 13a. STREET ADDRESS                                                                                                                                         |  |                                                                                                                            |                                              |
| 13a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                                      |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST <i>Will</i> MIDDLE <i>Canada</i> LAST <i>Canada</i>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Winnie</i> MIDDLE <i>Carter</i> LAST <i>Carter</i>                                                                     |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Unknown</i>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><i>22414 5471</i>                                                                                                               |  | 17. INFORMANT<br>ADDRESS<br><i>Stella C. Brown 3602 Spaulding Avenue</i>                                                   |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>multiple CVA.</i><br><i>3109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Chronic organic brain syndrome</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/24</i> , 19 <i>83</i> , to <i>1/21</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/23/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><i>Wm. C. March</i> DEGREE <i>MD</i>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>1/21/83</i>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><i>1/25/ 83</i>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Eastview Mem Pk.</i>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN <i>Baltimore</i> COUNTY <i>Co.</i> STATE <i>Md.</i>                                          |                                              |
| 24. FUNERAL DIRECTOR<br>NAME <i>Wm. C. March F/H Inc. 1101 E. North Avenue</i> ADDRESS                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 24 1983</i>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                                                        |                                              |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 8 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                   |  |                                                                                                                                                |                                                               |                                                                                                                                                             |                            |                                                                                                          |  |                                                                 |  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL Joseph CAVALLO, SR</b>          |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 4, 1983</b> |                                                                                                                                                             | 2b. HOUR<br><b>06:30AM</b> |                                                                                                          |  |                                                                 |  |
| 3. SEX<br><b>Male</b>                                                             |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9, 1916</b>                                                                                                  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>                                                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                                        |  |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                               |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Supervisor Beth Steel</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br><b>Maryland</b>                                                     |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                |                                                               | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>3023 Edgewood Rd 21234</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carmine Ralph Cavallo</b>            |  |                                                                                                                                                |                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucia DeFrancesco</b>                                                                                   |                            |                                                                                                          |  |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-8288</b>                                                                                                 |                                                               | 17. INFORMANT<br><b>Mrs Rita Cavallo</b>                                                                                                                    |                            | ADDRESS<br><b>Same</b>                                                                                   |  |                                                                 |  |

|                                                                                                                                                                 |  |                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1889 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 WKS</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC BLADDER CANCINOMA</b>                                                                                       |  | <b>4 YRS.</b>                                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                           |  |                                                                 |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **SEPSIS**

|                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 28, 1982</b> to <b>JAN. 4, 1983</b> , that (I) (we) last<br>saw the deceased alive on <b>JAN 3, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>E. Woods</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  | DEGREE<br><b>M.D.</b>                                                                |  | 22c. DATE SIGNED<br><b>1/04/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESSIE J. WOODS</b>                                                                                                                                                                                                                                                                                    |  |                                                                        |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital<br/>600N. Wolfe St. Balt. Md. 21205</b>    |  |                                                                                                                               |  |

|                                                                                        |  |                            |  |                                                            |  |                                                                          |  |
|----------------------------------------------------------------------------------------|--|----------------------------|--|------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          |  | 23b. DATE<br><b>1/8/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1AN 5198?</b>          |  |                                                                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2000-01-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                     |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  | REG. NO. 000783                                                                                                                    |  |                                   |  |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|----------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                          |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH                                                                                                            |  | MONTH DAY YEAR                    |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) Clarence L Chambers                                                                                                                                                                                                                                                                                        |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  | ESTIMATED <input checked="" type="checkbox"/> 1 3 1983                                                                             |  |                                   |  |          |  |
| 2. SEX M                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE B |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 2 29                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.       |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN                                                                                                                   |  | 2c. DATE PRONOUNCED DEAD 1 6 83                                                                                                    |  | 2d. HOUR 5:15 P.M.                |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND                                                                                                                                                                                                                                                                                          |  |           |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                               |  |                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                                                           |  |                                   |  |          |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                         |  |           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1804 Greenmount Avenue |  |                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry Conversation                                                                       |  |                                                                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |
| 13a. STATE M                                                                                                                                                                                                                                                                                                                                |  |           |  | 13b. COUNTY BALTIMORE                                                                                                          |  |                                               |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13d. STREET ADDRESS 1804 GREENMOUNT AVE 21202                                                                                      |  |                                   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elman Chambers                                                                                                                                                                                                                                                                                          |  |           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE Chambers                                                                      |  |                                               |  |                                                                                                                                                          |  |                                                                                                                                    |  |                                   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES                                                                                                                                                                                                                                                                      |  |           |  | 16b. SOCIAL SECURITY NO. 218-22 2427                                                                                           |  |                                               |  | 17. INFORMANT ADDRESS Gladys Robinson 2404 Calhoun St 21206                                                                                              |  |                                                                                                                                    |  |                                   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) Cirrhosis of the Liver<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |                                   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                         |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  |                                                                                                                                    |  |                                   |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  |           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                              |  |                                               |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  |                                   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                         |  |           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                           |  |                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                                                                    |  |                                   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                     |  |           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                    |  |                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                    |  |                                   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                                        |  |           |  |                                                                                                                                |  |                                               |  |                                                                                                                                                          |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                   |  |          |  |
| ACTUAL SIGNATURE Dennis F. Smyth M.D.                                                                                                                                                                                                                                                                                                       |  |           |  | TITLE (SPECIFY) Assistant MEDICAL EXAMINER                                                                                     |  |                                               |  | DATE SIGNED 1-7-83                                                                                                                                       |  |                                                                                                                                    |  |                                   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                       |  |           |  | ADDRESS 111 Penn Street                                                                                                        |  |                                               |  |                                                                                                                                                          |  |                                                                                                                                    |  |                                   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                   |  |           |  | 23b. DATE 1/13/83                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY Mt Calvary |  |                                                                                                                                                          |  | 23d. LOCATION (City or Town) COUNTY STATE Baltimore MD 21225                                                                       |  |                                   |  |          |  |
| 24. FUNERAL DIRECTOR NAME PHAYES 638 N Gilman St                                                                                                                                                                                                                                                                                            |  |           |  | ADDRESS                                                                                                                        |  |                                               |  | 25a. DATE REC'D BY REGISTRAR 17 JAN 1983                                                                                                                 |  |                                                                                                                                    |  |                                   |  |          |  |
|                                                                                                                                                                                                                                                                                                                                             |  |           |  |                                                                                                                                |  |                                               |  | 25b. REGISTRAR'S SIGNATURE John J. Connel                                                                                                                |  |                                                                                                                                    |  |                                   |  |          |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-bonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | REG. NO. 83 00784                                                                                                                                           |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ERNEST CHAPMAN</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 27, 1983</b>                                                                                                    |  |                                                                                                                         |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE <b>Black</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>7 31 27</b>                                                                                                              |  | 2b. HOUR <b>A 4:49 M</b>                                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                                                          |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>---</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>James Chapman</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Gant</b>                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO. <b>215-22-0193</b>                                                                                              |  | 17. INFORMANT ADDRESS <b>Erma Chapman - 1420 Fulton Ave.</b>                                                                                                |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>0389 IMMEDIATE CAUSE (a) Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Failure to wear</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>                                                                                                  |  |                                                                                                                         |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Failure to wear</b>                                                                                                                                                                                                                        |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27/83</b> to <b>1/27/83</b> , that (I) (we) last saw the deceased alive on <b>1/27/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Marc Nelson</b> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                              |  |                                                                                                                                          |  | 22c. DATE SIGNED <b>1/27/83</b>                                                                                                                             |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc Nelson</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 22e. ADDRESS <b>Johns Hopkins</b>                                                                                                                           |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE <b>2-1-83</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                                                       |  |
| 24. FUNERAL DIRECTOR NAME <b>Vernon R. Bailey</b> ADDRESS <b>21217 1348 N. Calhoun St.</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                                                           |  |                                                                                                                         |  |

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the certificate to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

00785

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                           |                                                                                                                                                             |                                       |                                                                                      |                                                                                                 |                                                                                                               |                                                            |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY KATHERINE CHASE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 - 12 - 83</b> |                                                                                                                                                             |                                       | 2b. HOUR<br><b>8:40 PM</b>                                                           |                                                                                                 |                                                                                                               |                                                            |                                                                                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>WHITE</b>                                                                                                                |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 07 12</b>                                                                                                       |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70 YRS.</b>                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>---</b>                                                    |                                                            |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                                                                                                 |                                                                                                               |                                                            |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |                                                           |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                               |                                                            |                                                                                                                            |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 13b. COUNTY<br><b>---</b>                                 |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                               | 13e. STREET ADDRESS<br><b>2010 BREITWERT AVENUE, 21230</b> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH KASINSKAS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE ZARDECKAS</b>                                                                                 |                                       |                                                                                      |                                                                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |                                                            | 16b. SOCIAL SECURITY NO.<br><b>216-07-8830</b>                                                                             |  |
| 17. INFORMANT<br><b>RONALD E. CHASE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                           | ADDRESS<br><b>ELLICOTT CITY, MD.</b>                                                                                                                        |                                       |                                                                                      |                                                                                                 | 18. DATE OF OPERATION<br><b>1.6.83.</b>                                                                       |                                                            | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Kidney stones &amp; Carcinoma left kidney.</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction, Anterior</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cardiovascular disease.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>S/P - Nephrectomy for Carcinoma, kidney.</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>&amp; ventricular Arrhythmias.</b><br>(c) <b>---</b> |  |                                                                                                                                        |                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>---</b>                                                                                                  |                                       |                                                                                      |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                           |                                                                                                                                                             |                                       |                                                                                      |                                                                                                 |                                                                                                               |                                                            |                                                                                                                            |  |
| 21a. DATE OF OPERATION<br><b>1.6.83.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                       |                                                                                      |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |                                                            | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>                                                            |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                           | 21f. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                   |                                       |                                                                                      |                                                                                                 | 21g. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |                                                            |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>83</b> , to <b>1/12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                               |  |                                                                                                                                        |                                                           |                                                                                                                                                             |                                       |                                                                                      |                                                                                                 |                                                                                                               |                                                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Kaushalendra Prakash Singh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                           | DEGREE<br><b>---</b>                                                                                                                                        |                                       |                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>1/12/83</b>                                                                            |                                                            |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAUSHALENDRAK. SINGH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                           | 22e. ADDRESS<br><b>ST. Agnes Hospital<br/>900 Caton Av., MD 212229.</b>                                                                                     |                                       |                                                                                      |                                                                                                 | 22f. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                                           |                                                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |                                                           | 23b. DATE<br><b>01-15-83</b>                                                                                                                                |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                                  |                                                            | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                           | ADDRESS<br><b>4107 WILKENS AVE.</b>                                                                                                                         |                                       | 24a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                  |                                                                                                 | 24b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                                        |                                                            |                                                                                                                            |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------|--|------------------|--|--------|--|------|--|----------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                         |  | FIRST                                                                                                     |  | MIDDLE                                                                               |  | LAST                                                                |  | 2a DATE OF DEATH    |  | MONTH            |  | DAY    |  | YEAR |  | 2b HOUR  |  |
| Ruth Johnson Chavis                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                      |  |                                                                     |  | Jan. 26, 1983       |  |                  |  |        |  |      |  | 925 A.M. |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                    |  | 5 DATE OF BIRTH                                                                      |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS. |  | MONTHS |  | DAYS |  | HOURS    |  |
| Female                                                                                                                                                                                                                                                                                                                                     |  | Black                                                                                                     |  | 5 7 37                                                                               |  | 45                                                                  |  | YRS.                |  |                  |  |        |  |      |  |          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                     |  |                  |  |        |  |      |  |          |  |
| North Carolina                                                                                                                                                                                                                                                                                                                             |  | USA                                                                                                       |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | Baltimore City                                                      |  |                     |  |                  |  |        |  |      |  | MD.      |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                  |  |        |  |      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                  |  | PROVIDENT HOSPITAL                                                                                        |  | Balto. School System                                                                 |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 13a STATE                                                                                                                                                                                                                                                                                                                                  |  | 13b COUNTY                                                                                                |  | 13c CITY OR TOWN                                                                     |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e STREET ADDRESS  |  |                  |  |        |  |      |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | Balto.                                                                               |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4023 Barrington Rd. |  |                  |  |        |  |      |  | 21207    |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                           |  | 15 MOTHER'S MAIDEN NAME                                                                                   |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| James                                                                                                                                                                                                                                                                                                                                      |  | Amos                                                                                                      |  | Callie                                                                               |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                        |  | 16b SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                                        |  | ADDRESS                                                             |  |                     |  |                  |  |        |  |      |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 4023 Barrington Rd. (Carl Johnson)                                                   |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                    |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                           |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 1749 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>                                                                                                                                                                                                                                                                                   |  | 10 min                                                                                                    |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                              |  | DUE TO, OR AS A CONSEQUENCE OF                                                                            |  | Pneumonia                                                                            |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                                            |  | DUE TO, OR AS A CONSEQUENCE OF                                                                            |  | Cause of Breast carcinoma                                                            |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a AUTOPSY?                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                  |  |        |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                  |  |        |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 24, 1983</u> to <u>Jan 26, 1983</u> , that (I) (we) last saw the deceased alive on <u>Jan 25, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                    |  | 22c. DATE SIGNED                                                                     |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                         |  | MD                                                                                                        |  | 1/26/83                                                                              |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                              |  |                                                                                      |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| A. Miranda                                                                                                                                                                                                                                                                                                                                 |  | 1010 St. Paul St.                                                                                         |  | 21102                                                                                |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                     |  |                  |  |        |  |      |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                                                     |  | 1/29/83                                                                                                   |  | Deer Park Cem.                                                                       |  | Maryland                                                            |  |                     |  |                  |  |        |  |      |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                           |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |
| Leroy O. Dyett 4600 Liberty Hgts. Ave.                                                                                                                                                                                                                                                                                                     |  | JAN 27 1983                                                                                               |  | John J. Conner                                                                       |  |                                                                     |  |                     |  |                  |  |        |  |      |  |          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



III

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Popsy doctor file returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  | 8 3 0 0 7 8 7                                                                                                                                               |  |                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GLADYS I. CHENOWETH                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-3-83                                                                                                                  |  | 2b. HOUR<br>9:30 A M                                                                                                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug 17, 1904                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>78 yrs                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br>Maryland -- Baltimore                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13c. STREET ADDRESS<br>4700 Harford Road (21214)                                                                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Auts                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Craig                                                                         |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>--                                                                        |  | 17. INFORMANT ADDRESS<br>George Chenoweth-434 W. 23rd St. (21211)                                                                                           |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>8880 IMMEDIATE CAUSE (a) Hypoxia<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Pneumonia or Pulmonary Embolism<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Chronic<br>Pneumonia vs. Immediate P.E. |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br>Fractured Right Hip                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>4:50 P.M. 12 31 83                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Fell ACCIDENT                                                             |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home-Nursing Home                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>4700 Harford Rd. Balt.                                                                                    |  |                                                                                                                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 1-3-83, 1983, that (I) (we) last saw the deceased alive on 1-3-83, 1983, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 22b. SIGNATURE<br>Charles P. Capito, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE                                                                                                                            |  | 22c. DATE SIGNED<br>1-3-83                                                                                                                                  |  |                                                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles P. Capito, M.D.                                                                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br>Union Memorial Hosp.                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>1/5/83                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem Pk                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                                                     |  |
| 24. FUNERAL DIRECTOR<br>A. Atan Seitz Funeral Home 3818 Roland Ave.                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1983                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                                                       |  |

BP

A. Allen Selfs Funeral Home 3818 Holman Av.

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Burial 1/2/87 New York New York Baltimore, Maryland

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No 220-11-7000 M George Chaseworth-1311 W. 32nd St. (21211)

Maryland - - Baltimore

Honolulu

U.S.A. xx

White Aug 17, 1911 30 yrs





| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                |                                                                                      |                                                                        |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             |                                                                     |                                                                                                                                                             | REG. NO.                                                                       |                                                                                      |                                                                        |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Francis L. Chrisman</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01 17 '83</b>                           |                                                                                      |                                                                        |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Cauc.</b>                                                                                                     |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 01 1897</b>                                                                                                        |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                    |                                                                        | 7b. HOUR<br><b>M</b>                                                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                  |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co. City MD.</b>                |                                                                        |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>City Hosp.</b> |                                                                     |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>      |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 13b. CITY OR TOWN<br><b>City</b>                                               |                                                                                      | 13c. STREET ADDRESS<br><b>6744 Bessemer Ave, 21222</b>                 |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>? ? Chrisman</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Almira ?</b>                  |                                                                                      |                                                                        |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>WW I</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>716-09-9149</b>                                 |                                                                                      | 17. INFORMANT ADDRESS<br><b>Dora Chrisman 6744 Bessemer Ave. 21222</b> |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Coronary Artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HBP</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b> |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                |                                                                                      |                                                                        |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Parkinson's Disease</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                |                                                                                      |                                                                        |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |  |                                                                                                                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                        |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                      |                                                                        |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-25</b> 19 <b>81</b> to <b>9-28</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>9-28</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                 |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                |                                                                                      |                                                                        |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>John Andersm</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 22c. DATE SIGNED<br><b>1-18-83</b>                                             |                                                                                      |                                                                        | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Andersm</b>                                                               |  |
| 22e. ADDRESS<br><b>Gr. Dundalk Med Ctr.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                |                                                                                      |                                                                        |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                             | 23b. DATE<br><b>01/20/83</b>                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>                  |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>        |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Dabrowski - 1005 Dundalk Avenue 21224</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>                            |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                    |                                                                                                                            |  |

130  
131  
135  
130  
2  
2  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1005 GARDNER AVENUE 11375

701/10/52 CARBONS DE FAICH

Baltimore

10.

10.1

710-04-9149 Dora Christian 0746 Bessmer Ave. 11313

1

CHRISTIAN ALBERTA

1

1001 Lang

X

0746 Bessmer Ave. 11313

Baltimore

City Hosp.

1001

1001

1001

Baltimore Co.

1001

1001

0746 Bessmer Ave. 11313

1001

FRANCIS L.

CHRISTIAN

10.17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

BP 9

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 8 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                      |                                        |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>- George                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        | 2a. DATE OF DEATH<br>January 16, 1983                                  |                                                                                                                                                             |                                                                  | 2b. HOUR<br>12:15A M                                                                                                                                 |                                        |                                                                                                                            |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>July 8, 1926                                                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                                                                                           |                                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                           |                                        |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |                                                                        |                                                                                                                                                             |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance                                                                      |                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital                                                                              |                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Baltimore                                                                                                               |                                                                        | 13c. CITY OR TOWN<br>Cockeysville                                                                                                                           |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                        | 13e. STREET ADDRESS<br>48 Sugar Tree Place 21030                                                                           |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                    |                                                                  |                                                                                                                                                      |                                        |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                       |                                                                        | 17. INFORMANT<br>ADDRESS<br>21030                                                                                                                           |                                                                  | Beatrice P. Bernstein 48 Sugar Tree Place                                                                                                            |                                        |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Carcinoma of the Lung, with Metastasis to the Liver<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                      |                                        |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                      |                                        |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                        |                                        |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                        |                                                                                                                            |                                              |
| 22a. I certify that (this hospital) attended the deceased from January 10, 1983, to January 16, 1983, that (I) (we) lost saw the deceased alive on January 16, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not know the body after death.                                                                       |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                                      |                                        |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>Michael G. Hayes, M.D.                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                        | 22c. DATE SIGNED<br>1-16-83                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael G. Hayes                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                        |                                        |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        | 23b. DATE<br>1/19/83                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Garden |                                                                                                                                                      | 23d. LOCATION<br>BALTIMORE COUNTY, Md. |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home P.A. 1407 Old Eastern                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                                                                                         |                                        | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                               |                                              |

MEDICAL CERTIFICATION



|             |             |              |             |                 |
|-------------|-------------|--------------|-------------|-----------------|
| Male        | White       | July 1, 1926 | 25          | January 1, 1983 |
| Tennessee   | U.S.A.      |              |             |                 |
| Birth date  | Birth place | Birth date   | Birth place | Birth date      |
| Unknown     | Unknown     | Unknown      | Unknown     | Unknown         |
| Yes         | No          | Yes          | No          | Yes             |
| 100 16 7198 | 100 16 7198 | 100 16 7198  | 100 16 7198 | 100 16 7198     |

Calculation of the time, with reference to the time

|             |             |             |             |             |             |
|-------------|-------------|-------------|-------------|-------------|-------------|
| Birth date  | 1/1/83      | Birth date  | 1/1/83      | Birth date  | 1/1/83      |
| Birth place | Birth place | Birth place | Birth place | Birth place | Birth place |
| Birth date  | Birth date  | Birth date  | Birth date  | Birth date  | Birth date  |
| Birth place | Birth place | Birth place | Birth place | Birth place | Birth place |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | REG. NO.                                                                                                                                    |  | 83 00790                                                                                                                                                    |  |                                                                                   |  |                                                                                                                         |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>George J. Christopoulos</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>8</b> YEAR <b>83</b>                                                                                                |  | 2b. HOUR <b>10:07</b> P.M.                                                        |  |                                                                                                                         |  |
| 3 SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE <b>Cauc.</b>                                                                                                                         |  | 5. DATE OF BIRTH MONTH <b>5</b> DAY <b>16</b> YEAR <b>20</b>                                                                                                |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.                                     |  | 7 UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN.                                                           |  |
| 8 BIRTHPLACE (STATE OR FOREIGN) <b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                     |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Corp.</b>                                                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN <b>Anne Arundel, Glen Burnie</b>                                                                                          |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13d. STREET ADDRESS <b>1658 Furnace Dr. 21061</b>                                 |  |                                                                                                                         |  |
| 14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>Christopoulos</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sophi</b> MIDDLE <b></b> LAST <b>Smetnoski</b>                                                            |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO. <b>214-20-3765</b>                                                                                                 |  | 17. INFORMANT <b>Helen Christopoulos, Same as 13</b> ADDRESS <b></b>                                                                                        |  |                                                                                   |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5609</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/8/83</b><br><b>1/7/83</b><br><b>12/23/82</b>                                                |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>a</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION <b>1/5/83</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute abdominal obstruction</b>                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b>19</b> P.M.                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                   |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>                                                                              |  |                                                                                   |  |                                                                                                                         |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>12/21</b> , 19 <b>82</b> , to <b>1/8/83</b> , 19 <b>83</b> , that (1) <input checked="" type="checkbox"/> I saw the deceased die on <b>1/8/83</b> , 19 <b>83</b> , and that in (my) <input checked="" type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, <input type="checkbox"/> ) |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Lawrence R. Bell III</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                   |  | 22c. DATE SIGNED <b>1/8/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lawrence R. Bell III</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | 22e. ADDRESS <b>3001 S. Hanover St., Baltimore, Md.</b>                                                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE <b>12 Jan 83</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>AA</b> STATE <b>MD</b>      |  |                                                                                                                         |  |
| 24 FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b> ADDRESS <b></b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | 25a. DATE RECD. BY REGISTRAR <b>JAN 11 1983</b>                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>                                  |  |                                                                                                                         |  |

BP





Items #10a-22a Film G577 3/21/83 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 000791

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  |                                                             |                |                  |                                                                               |          |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------|-------------------------------------------------------------|----------------|------------------|-------------------------------------------------------------------------------|----------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         |                  | 2a. DATE KNOWN OF DEATH                                     |                |                  | 2b. HOUR                                                                      |          |                                              |
| BERNARD M. CLARK                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | ESTIMATED MONTH DAY YEAR<br>1 18 19 83                      |                |                  | 1 18 19 83                                                                    |          |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)                                           | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD                                                      | 2d. HOUR |                                              |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     | Black   | 5 25 1951        | 31 YRS.                                                     | MONTHS         | DAYS             | 1 18 19 83                                                                    | 4:06     |                                              |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |          |                                              |
| Wilmington, N.C.                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | U.S.A.                                                      |                |                  | Baltimore City                                                                |          |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |          |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                  | 2525 Druid Hill Ave.                                        |                |                  | Laborer                                                                       |          |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                  | 13b. COUNTY                                                 |                |                  | 13c. CITY OR TOWN                                                             |          |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                  | Baltimore                                                   |                |                  | Baltimore                                                                     |          |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                  | 15. MOTHER'S MAIDEN NAME                                    |                |                  | 17. INFORMANT ADDRESS                                                         |          |                                              |
| Joseph Earl Clark Sr.                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                  | Louise P. Andrews                                           |                |                  | Lynda Fellows 1226 Bloomingdale Rd.                                           |          |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                             |         |                  | 16b. SOCIAL SECURITY NO.                                    |                |                  | 17. INFORMANT ADDRESS                                                         |          |                                              |
| (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                  | (IF YES, GIVE WAR OR DATES)                                 |                |                  | Lynda Fellows 1226 Bloomingdale Rd.                                           |          |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |         |                  |                                                             |                |                  |                                                                               |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>                                                                                                                                                                                                                                                                                                                                                                                              |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| 4850                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                            |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| (b) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                       |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |                  | 20. AUTOPSY?                                                                  |          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  |                                                             |                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |          |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |         |                  | 21b. TIME OF INJURY                                         |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |                |                  |                                                                               |          |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                |                  | 21f. LOCATION                                                                 |          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  |                                                             |                |                  | CITY OR TOWN COUNTY STATE                                                     |          |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |                                                             |                |                  |                                                                               |          |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | TITLE (SPECIFY)                                             |                |                  | DATE SIGNED                                                                   |          |                                              |
| Ann M. Dixon                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                  | M.D. Assistant MEDICAL EXAMINER                             |                |                  | 1-18-83                                                                       |          |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  | ADDRESS                                                     |                |                  |                                                                               |          |                                              |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                  | 111 Penn St., Balto., Md. 21201                             |                |                  |                                                                               |          |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         |                  | 23b. DATE                                                   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY                                            |          |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                  | 1/24/83                                                     |                |                  | Mt. Calvary                                                                   |          |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  | 25a. DATE REC'D. BY REGISTRAR                               |                |                  | 25b. REGISTRAR'S SIGNATURE                                                    |          |                                              |
| Wm C. Brown Comm. F/H 1206-08 W. North Ave.                                                                                                                                                                                                                                                                                                                                                                                              |         |                  | FEB 24 1983                                                 |                |                  | John J. Maryland                                                              |          |                                              |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





RECEIVED

3832



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 9 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                       |  |                                                                                                                                                |                                                        |                                                                                                                                                             |  |                                                                                        |  |
|---------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES ROBERT CLARK</b> |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/29/83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10:55</b>                                                               |  |
| 3. SEX<br><b>Male</b>                                                                 |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 6 1939</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b>                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Line super.</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B.G. &amp; E.</b>                             |  | 13a. STREET ADDRESS<br><b>4151 Fox Trail Road</b>                                                                                              |                                                        |                                                                                                                                                             |  |                                                                                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Erskine (NIN) Clark</b>                  |  |                                                                                                                                                |                                                        |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charity Ann Blevins</b>            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>    |  | 16b. SOCIAL SECURITY NO.<br><b>192-32-3528</b>                                                                                                 |                                                        | 17. INFORMANT <b>Brother</b><br>ADDRESS<br><b>Edward Clark 90 Farah Dr. Elkton, Md. 21921</b>                                                               |  |                                                                                        |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4151

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **Suspected Pulmonary Embolism**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

45 min

5 min

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**hyperkalemia**

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8</b> , 19 <b>83</b> , to <b>Jan 29</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 29</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>R A Lange</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>1/29/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R A Lange</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                        |  |                                                                                                                               |  |

|                                                            |  |                                  |  |                                                                   |  |                                                                  |  |
|------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>Feb. 1, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harford Mem. Gardens</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harford Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell Funeral Home P.A.</b>  |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1983</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must notify the medical examiner's office.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  | 83 00 / 93                                                                                                                                                 |  |                                                                                                                               |                                                                 |
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| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | REG. NO.                                                                                                                                                   |  |                                                                                                                               |                                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOWELL ROSCOE CLARK</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 - 5 - 83</b>                                                                                                   |  | 2b. HOUR<br><b>815 A.M.</b>                                                                                                   |                                                                 |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>BLACK</b>                                                                                                               |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 23 1895</b>                                                                                                   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                                                              |                                                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                              |                                                                 |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2230 MADISON AVE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITER - RAILROAD CAR</b>                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                                 |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                            |  | 13c. STREET ADDRESS<br><b>2230 MADISON AVE, 21217</b>                                                                         |                                                                 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN H. CLARK</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JULIA M. TYNES</b>                                                                                     |  |                                                                                                                               |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b>                                                                |  | 17 INFORMANT<br>ADDRESS<br><b>WARDELL CLARK 716 WASHINGTON PL.</b>                                                                                         |  |                                                                                                                               |                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio Sclerotic CardioVascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Insufficiency</b> |  |                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Angina Pectoris</b>                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                                                               |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                               |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                               |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 81</b> to <b>1-5 19 83</b> , that (I) (most) saw the deceased alive on <b>Nov. 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                     |  |                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                                                               |                                                                 |
| 22b. SIGNATURE<br><b>Joseph E. Piszczek, M.D.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | DEGREE<br><b>M.D.</b>                                                                                                                                      |  | 22c. DATE SIGNED<br><b>1-5-83</b>                                                                                             |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH PISZCZEK</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | 22e. ADDRESS<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                           |  |                                                                                                                               |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>1/11/1983</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                       |                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Hutter</b>                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>3035 W. North Ave.</b>                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                           |                                                                 |



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Items 4, 21a, 22a G576 2/18/83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 7 9 4

1. FOR  
STATE  
REGISTRAR

dad

REG. NO.

|                                                                                                                 |                                                                                                                               |                                                                                                                                                             |                                                                                                |                                                                                  |  |                                           |                                           |  |
|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--|-------------------------------------------|-------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna Irene Cline                                                         |                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>1/27/83                                                                   |                                                                                  |  | 2b. HOUR<br>11 AM                         |                                           |  |
| 3. SEX<br>F                                                                                                     | 4. RACE<br>caucasian                                                                                                          | 5. DATE OF BIRTH<br>July 8, 1896<br>MONTH 7 DAY 8 YR 96                                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86                                                          |                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Va.                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                                         |                                                                                  |  |                                           |                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Balto                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto City Hosp. |                                                                                                                                                             |                                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House duties |  |                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>W. Va. Berkeley |                                                                                                                               |                                                                                                                                                             | 13b. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                  |  | 13c. STREET ADDRESS<br>Rt 2 99999         |                                           |  |
| 14. FATHER'S NAME<br>(FIRST) John (MIDDLE) Adam (LAST) Speck                                                    |                                                                                                                               |                                                                                                                                                             | 15. MOTHER'S NAME<br>(FIRST) Alice (MIDDLE) Virginia (LAST) Triggs                             |                                                                                  |  |                                           |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                      |                                                                                                                               |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>233-96-4975                                                        |                                                                                  |  | 17. INFORMANT<br>Marshall Speck           |                                           |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY:

8939

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Sepsis, Renal Failure, Myocardial Depression 2 wks

DUE TO, OR AS A CONSEQUENCE OF

(c)

Burns

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

12/22/82

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |  |                                                                                                                       |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>1/24/83                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Burns to chest                                                                                   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input checked="" type="checkbox"/>                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12 P.M. 12 22 82                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Clothing caught fire while cooking. |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home                                                                       |  | 21f. LOCATION<br>(STREET)<br>Rt 2                                                                                     |  | 21g. CITY OR TOWN<br>Baltimore                                                                                                |  |
| 21h. COUNTY<br>West Vir.                                                                                                                                                                                                                                                                                                           |  | 21i. STATE<br>WV                                                                                                                                     |  |                                                                                                                       |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22/82, 19____, to 1/24/83, 19____, that (I) (we) lost<br>saw the deceased alive on 1/24/83, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (they) did not view the body after death. |  |                                                                                                                                                      |  |                                                                                                                       |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>D Weinstein                                                                                                                                                                                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/24/83                                                                                           |  |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald Weinstein                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br>Balto. Regional Burn Center                                                                                                          |  |                                                                                                                       |  |                                                                                                                               |  |

|                                                                                                      |  |                          |  |                                                            |  |                                                                       |  |
|------------------------------------------------------------------------------------------------------|--|--------------------------|--|------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                               |  | 23b. DATE<br>Feb. 1 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bunker Hill Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bunker Hill Berkeley WV |  |
| 24. FUNERAL DIRECTOR<br>NAME Charles M. Brown<br>Brown Funeral Home<br>P.O. Box 821, Martinsburg, WV |  |                          |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983                |  |                                                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br>John A. Davis                                                          |  |                          |  |                                                            |  |                                                                       |  |





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TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The copies for the Baltimore City Health Department, the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |  | 8 3 0 0 / 9 5                                                                                                                                               |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GENEVA V. COATES</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 01 1983</b>                                                                                                    |  | 2b. HOUR<br><b>7:49P</b>                                                                                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 5 24</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                           |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13d. STREET ADDRESS<br><b>3121 Oakford Avenue 21215</b>                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ford Jacks</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan Mackell</b>                                                                                       |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>212 34 8213</b>                                                                                                 |  | 17. INFORMANT<br>ADDRESS<br><b>Jean Jacks 3121 Oakford Avenue</b>                                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>82</b> to <b>1/1</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Clair A. Franconano MD</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>1/1/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLAIR A. FRANCONANO MD</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                               |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>1/7/83</b>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Patuxent Church Cem.</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Calvert Co., Md.</b>                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James A. Morton &amp; Sons 1701 Laurens St.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1983</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |  |



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                          |                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      | REG. NO. 83 00796                                                         |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE AND PRINT)<br>Rachela (Agnes) Coccia                                                                                                                                                                                                                                                                                   |                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan 8, 1983                                                                                                      |                                                                           | 2b. HOUR<br>3:25 PM                                                                                                        |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>Caucasian                                                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 21 1896                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                                                                                           |                                                                           | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                                                                                |                                                                           |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>City Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>home                                 |                                                                                                                            |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                              |                                                                                                                         |                                                                                                                                                             | 13b. COUNTY<br>Balto                                                                                                                                 | 13c. CITY OR TOWN<br>Balto                                                | 13d. STREET ADDRESS<br>3902 Clement St.                                                                                    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Vincenzo Juliano                                                                                                                                                                                                                                                                                       |                                                                                                                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Philomena Bochino                                                                                             |                                                                                                                                                      |                                                                           |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>No                                                                                                                                                                                                                                             |                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>220-01-2863                                                                                                                     | 17. INFORMANT ADDRESS<br>Joseph Coccia 3406 E. Pratt St.                                                                                             |                                                                           |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Inferior Myocardial Infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) ASCVD |                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                            |                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                           |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |                                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                        |                                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |                                                                           |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 1983, to 1/8 1983, that (I) (we) last saw the deceased alive on 1/8 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                           |                                                                                                                            |
| 22b. SIGNATURE<br>Richard Bennett                                                                                                                                                                                                                                                                                                             |                                                                                                                         |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                           | 22c. DATE SIGNED<br>1/8/83                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Bennett                                                                                                                                                                                                                                                                                      |                                                                                                                         |                                                                                                                                                             | 22e. ADDRESS                                                                                                                                         |                                                                           |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)<br>Burial                                                                                                                                                                                                                                                                                              | 23b. DATE<br>1-12-83                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cem.                                                                                                          |                                                                                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland             |                                                                                                                            |
| 24. FUNERAL DIRECTOR NAME<br>Joseph N. ZANNINO 263 S. CONKLING ST.                                                                                                                                                                                                                                                                            |                                                                                                                         |                                                                                                                                                             | 25a. DATE RECD. BY REGISTRAR<br>Jan 10 1983                                                                                                          |                                                                           | 25b. REGISTRAR'S SIGNATURE<br>John J. Gough                                                                                |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                     |  | REG. NO. 83 00797                                                                                                                                        |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                     |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST                                                                                                       |  |                                                                                                                         |  |
| ALBERT A. COHEN                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  |                                                                                                                         |  |
| JANUARY 22, 1983                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                     |  | 2b. HOUR ± 2 A.M.                                                                                                                                        |  |                                                                                                                         |  |
| 3. SEX MALE                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE WHITE                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  |
| FEB. 16, 1944                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 38                                                                  |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                                              |  | IF UNDER 24 HRS. HOURS MIN.                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2205 ROGENE DR., APT. 101                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRODUCER                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY SHOWS                                                                                 |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                   |  |                                                                                                                         |  |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                       |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS                                                                                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                                                                         |  |
| BERNARD C. COHEN                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                     |  | RUTH L. LEVENSON                                                                                                                                         |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                     |  | 16b. SOCIAL SECURITY NO. ARMY-VIET NAM 215-42-7565                                                                                                       |  | 17. INFORMANT                                                                                                           |  |
| BERNARD C. COHEN APT. 101                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                     |  | 2205 ROGENE DR. BALTO., MD 21209                                                                                                                         |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable cardiac arrhythmia</u><br>3970 DUE TO, OR AS A CONSEQUENCE OF (b) <u>prolonged endocarditis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |  |                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>S/P ruptured mycotic aneurysm, intracerebral bleed</u>                                                                                                                                                                                                                                                   |  |                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) this hospital attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                                                                                                                                                                                                                       |  |                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE PETER OROSZLAN, M.D.                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                     |  | 22e. ADDRESS                                                                                                                                             |  | JAN. 22, 1983                                                                                                           |  |
| PETER OROSZLAN, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                     |  | 600 REISTERSTOWN RD. BALTO., MD 21208                                                                                                                    |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE JAN 24, 1983                                              |  | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY MARYLAND                                                                              |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                                          |  |                                                                     |  | 25a. DATE REC'D. BY REGISTRAR JAN 26 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                                                                     |                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | 8 3 0 0 7 9 8                                                                                                                                                       |                                                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | 2a. DATE OF DEATH                                                                                                                                                   |                                                                     |
| FIRST MIDDLE LAST<br>EMILY COHEN                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | MONTH DAY YEAR<br>JANUARY 24, 1983                                                                                                                                  |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | 2b. HOUR                                                                                                                                                            |                                                                     |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | 11:28A <sup>M</sup>                                                                                                                                                 |                                                                     |
| 4. RACE                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. DATE OF BIRTH                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                                     |                                                                     |
| WHITE                                                                                                                                                                                                                                                                                                                                                                                                                                               | MONTH DAY YEAR<br>MARCH 15, 1920                                       | 62 YRS.                                                                                                                                                             |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |                                                                     |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                            | U.S.A.                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                |                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                       |                                                                     |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | HOUSEWIFE                                                                                                                                                           |                                                                     |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                                                                                                                                              |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                   |                                                                     |
| 2209 CROSS COUNTRY BLVD. 21209                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | AT HOME                                                                                                                                                             |                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13b. COUNTY                                                            | 13c. CITY OR TOWN                                                                                                                                                   | 13d. INSIDE CITY LIMITS?                                            |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | BALTIMORE                                                                                                                                                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                            |                                                                     |
| FIRST MIDDLE LAST<br>BENJAMIN SAMLER                                                                                                                                                                                                                                                                                                                                                                                                                | FIRST MIDDLE LAST<br>SARAH MACHT                                       |                                                                                                                                                                     |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                   | 16b. SOCIAL SECURITY NO.                                               | 17. INFORMANT ADDRESS                                                                                                                                               |                                                                     |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 215-24-3171                                                            | MR. H. WILLIAM COHEN 2209 CROSS COUNTRY BLVD. 21209                                                                                                                 |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Metastatic breast cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 1/2 years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 minutes</u> |                                                                        |                                                                                                                                                                     |                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                                                                     |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?                                                                                                                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                      |                                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                   |                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>77</u> , to <u>January 24</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>January 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                         |                                                                        |                                                                                                                                                                     |                                                                     |
| 22b. SIGNATURE<br><u>Martha Linet</u>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | DEGREE<br><u>M.D.</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>1/24/83</u>                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. MARTHA LINET                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | 22e. ADDRESS<br>615 N. WOLF ST.                                                                                                                                     |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. DATE                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |
| CREMATION                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1/26/83                                                                | LOUDON PARK CREM                                                                                                                                                    | BALTIMORE MARYLAND                                                  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                                                                                                                                                                                                                                                                                                                                          |                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><u>John J. [Signature]</u>            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | FEB 1 1983                                                                                                                                                          |                                                                     |

MEDICAL CERTIFICATION





6/11/11

RECEIVED

OFFICE

2011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | 8                                                                             | 3 | 0                              | 0                                            | 7                                                                                    | 9          | 9                                                                                                                                          |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---|--------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | REG. NO.                                                                      |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marian M. Cohen                                                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-3-83<br>2b. HOUR<br>647 P.M.         |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | 4. RACE<br>White                                                                                                        |  |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 17 16                                                                                                               |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                                                 |                                                                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS |                                              | IF UNDER 24 HRS.<br>HOURS MIN.                                                       |            |                                                                                                                                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                    |  |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                                                                    |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Mem. |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY            |                                                                                      |            |                                                                                                                                            |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | 13b. COUNTY                                                                   |   | 13c. CITY OR TOWN<br>Balto.    |                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |            | 13e. STREET ADDRESS<br>123 W. 29th St. 21218                                                                                               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Vanderlinder                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose |                                                                                                                                                             |  |  |                                                                                                                            |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>129-16-4844                                                  |  |                                                       | 17. INFORMANT<br>Wilta Neugebauer                                                                                                                           |  |  | ADDRESS<br>8 Huston, Texas<br>8010 Belle Glen Drive                                                                        |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>ASCVD, POSTERIOR MI, CHF, 1st DEGREE AV BLOCK, 1st DEGREE VENTRIC. TACH.</u> |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>UNKNOWN                       |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1st DEGREE AV BLOCK, POSTERIOR MI, CHF, 1st DEGREE VENTRIC. TACH.</u>                                                                                                                                                                                                              |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                   |  |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19                                                            |  |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—                                                                         |  |  |                                                                                                                            |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)<br>—                                             |  |                                                       | 21f. LOCATION<br>STREET<br>—                                                                                                                                |  |  | CITY OR TOWN<br>—                                                                                                          |                                                                               |   | COUNTY<br>—                    |                                              |                                                                                      | STATE<br>— |                                                                                                                                            |  |  |  |
| 22a. I certify that (1) the hospital attended the deceased from <u>DEC. 1981</u> , to <u>1/3 1983</u> , that (1) <u>was</u> last saw the deceased alive on <u>10/29/82</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (b) <u>was</u> (did) <u>not</u> view the body after death.                                                          |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 22b. SIGNATURE<br><u>Vincent A. DiPietro</u>                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | DEGREE<br><u>MD</u>                                                           |   |                                | 22c. DATE SIGNED<br>1/3/83                   |                                                                                      |            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anatomy Board                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | 22e. ADDRESS<br>Balto., Md.                                                   |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                                                                                   |  |  | 23b. DATE<br>1/10/83                                                                                                    |  |                                                       | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                           |                                                                               |   |                                |                                              |                                                                                      |            |                                                                                                                                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board                                                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                         |  |                                                       |                                                                                                                                                             |  |  |                                                                                                                            | ADDRESS<br>Balto., Md.                                                        |   |                                | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1983 |                                                                                      |            | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                                                                                        |  |  |  |

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Vincent A. J. (Lester, W.)

1/2/23

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |                                                                                      |                                                                                                                                                             |                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEON Trustan COKER                                                                                                                                                                                                                                                                                       |  |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 1, 1983                               |                                                                                                                                                             |                                                         | 2b. HOUR<br>1:50 <sup>M</sup>                                                                                                              |                                                                                                 |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                             |                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 12 06                                                                                                               |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                                                                                 |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       |                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |                                                                                      |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eastern Stair Steel                                                                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              | 13b. COUNTY                                                                          |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                          |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joshua Green Coker                                                                                                                                                                                                                                                                                    |  |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia ?                          |                                                                                                                                                             |                                                         | 13e. STREET ADDRESS<br>2324 Cambridge St. 21231                                                                                            |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>_____                                                                                            |                                                                                      | 17. INFORMANT<br>ADDRESS<br>Mary Alice Rose 735 Shipfriend Road 21222                                                                                       |                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br><u>4960</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>pneumonia / septicemia</u><br>(c) <u>aspiration / COPD</u> |  |                                                                                                                              |                                                                                      |                                                                                                                                                             |                                                         |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>min</u><br><u>days</u><br><u>weeks</u>                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                               |  |                                                                                                                              |                                                                                      |                                                                                                                                                             |                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |                                                                                                                                                             |                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |                                                                                                                                                             |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                    |  |                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |                                                                                                                                                             |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/82</u> to <u>1/1/83</u> , that (I) (we) last saw the deceased alive on <u>1/1/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                             |  |                                                                                                                              |                                                                                      |                                                                                                                                                             |                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>John Mannisi</u> MD                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              | DEGREE<br>MD                                                                         |                                                                                                                                                             |                                                         | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>1/1/83                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Mannisi MD                                                                                                                                                                                                                                                                                        |  |                                                                                                                              | 22e. ADDRESS<br>100 CHURCH HOSPITAL CORPORATION<br>N. BROADWAY, BALTIMORE, MD. 21231 |                                                                                                                                                             |                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                          |  |                                                                                                                              | 23b. DATE<br>1-5-83                                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eastwood, Balto. Co. Md.                          |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C.S. Zeiler & Son Inc. 901 S. Conkling Street                                                                                                                                                                                                                                                                   |  |                                                                                                                              | ADDRESS                                                                              |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1983             |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                    |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



|        |          |   |    |    |
|--------|----------|---|----|----|
| Notes  | White    | 7 | 12 | 78 |
| Part 1 | 11.2.4   | x |    |    |
| Part 2 | (Part 1) |   |    |    |
| Part 3 | Part 1   | x |    |    |
| Part 4 | Part 1   |   |    |    |
| Part 5 | Part 1   |   |    |    |

Part 1  
Part 2  
Part 3  
Part 4  
Part 5

Part 1  
Part 2  
Part 3  
Part 4  
Part 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  | REG. NO. 8300801                                                                                                                                            |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) AKA FIRST L. MIDDLE EDWARD LAST COLEMAN<br>/ LOUIS EDWARD COLEMAN                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 19 83                                                                                                                 |  | 2b. HOUR<br>4 AM                                                                                                           |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>01 20 19                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3906 Colchester Road |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ASSISTANT                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AUCTION GALLERY                                                                       |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br>---                                                                                                             |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LOUIS H. COLEMAN                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LOUISE UNKNOWN                                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>WW II 212-14-1253                                                                                  |  | 17. INFORMANT<br>GEMMA COLEMAN                                                                                                                              |  | ADDRESS<br>3906 COLCHESTER ROAD, 21229                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MULTIPLE MYELOMA<br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                            |  |
| 21g. I certify that (I) (this hospital) attended the deceased from OCTOBER 18, 1983, to JANUARY 19, 1983, that (I) (we) last saw the deceased on JANUARY 19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not saw the body after death.                                        |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 21h. SIGNATURE                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | DEGREE                                                                                                                                                      |  | 21i. DATE SIGNED                                                                                                           |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DIANA GRIFFITHS, M.D.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | 22b. ADDRESS<br>St. Agnes Hosp. 3rd Flr.                                                                                                                    |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>01-21-83                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PK. MAUSOLEUM                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                               |  |

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(M)





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate completed.

41

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 0 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH A. COLEMAN</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-27-83</b>                 |                                                                                                                                                             | 2b. HOUR<br><b>2:15 P.M.</b>                                     |                                                                                                 |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE<br><b>BLACK</b>                                                                                                                    |                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-16-00</b>                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b><br>YRS. MONTHS DAYS HOURS MIN.                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b> |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                               |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Jones</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Parhina Mosley</b> |                                                                                                                                                             |                                                                  |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>217 22 1212</b>                                                                                            |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Harold Prince 2207 Aiken St.</b>                                                                                             |                                                                  |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) DEHYDRATION; MIANITION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SQUAMOUS CELL CA, LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                  |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                         |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                  |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                  |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-23</b> , 19 <b>83</b> , to <b>01-27-83</b> , that (I) (we) last saw the deceased alive on <b>01-27-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                         |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |
| 22b. SIGNATURE<br><b>Cesar Gamboa, M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                      |  |                                                                                                                                           |                                                                        | 22c. DATE SIGNED<br><b>01-27-83</b>                                                                                                                         |                                                                  |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR GAMBOA, M.D.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                        | 22e. ADDRESS<br><b>N. CHARLES GENERAL HOSPITAL</b>                                                                                                          |                                                                  |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>1/31/83</b>                                                                                                               |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                               |                                                                  |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Arbutus</b>                                                                                                                                                                                                                                                                                                                                       |  | COUNTY<br><b>Md.</b>                                                                                                                      |                                                                        | STATE                                                                                                                                                       |                                                                  |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North avenue</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1983</b>                                                                                                         |                                                                  |                                                                                                 |
| ADDRESS                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |                                                                        | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gwinn</b>                                                                                                          |                                                                  |                                                                                                 |

BP



JAN 8 1963  
J. G. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  | 8                                                                                                                       | 3 | 0                                 | 0 | 8        | 0 | 3 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|---|-----------------------------------|---|----------|---|---|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  | REG. NO.                                                                                                                |   |                                   |   |          |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          | FIRST MIDDLE LAST                                    |                                                                                                                                               |                                                        |                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |   |                                   |   | 2b. HOUR |   |   |
| LILLY E. CONKLIN                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  | JAN. 18 1983                                                                                                            |   |                                   |   | 6:45A    |   |   |
| 3. SEX                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                                      |                                                                                                                                               |                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)                                                   |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |   | IF UNDER 24 HRS. HOURS MIN.       |   |          |   |   |
| FEMALE                                                                                                                                                                                                                                                                                                                              |  | WHITE                                                                                                  |  | APRIL 15 1906                                                                                                                                            |                                                      |                                                                                                                                               |                                                        | 76 YRS.                                                                           |  |                                                                                                                         |   |                                   |   |          |   |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      |                                                                                                                                               |                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                              |  |                                                                                                                         |   |                                   |   |          |   |   |
| MD.                                                                                                                                                                                                                                                                                                                                 |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        | BALTIMORE CITY MD.                                                                |  |                                                                                                                         |   |                                   |   |          |   |   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |          |   |   |
| BALTIMORE                                                                                                                                                                                                                                                                                                                           |  | UNION MEMORIAL HOSPITAL                                                                                |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  | HOMEMAKER                                                                                                               |   | -                                 |   |          |   |   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |                                                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |                                                        | 13e. STREET ADDRESS                                                               |  |                                                                                                                         |   |                                   |   |          |   |   |
| MD.                                                                                                                                                                                                                                                                                                                                 |  | -                                                                                                      |  | BALTIMORE                                                                                                                                                |                                                      | YES                                                                                                                                           |                                                        | 3408 BRENDAN AVENUE 21213                                                         |  |                                                                                                                         |   |                                   |   |          |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST           |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| IRA PECK                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          | OLIVE REEL                                           |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) |                                                                                                                                               | 17. INFORMANT ADDRESS                                  |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
|                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          | 212-26-7143                                          |                                                                                                                                               | EVELYN HARBY (DGHT) 5445 El Camino COLUMBIA, MD. 21044 |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 1539 } DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                      |                                                                                                                                               |                                                        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                   |   |          |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                  |  |                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                             |  |                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 8, 19 83, to JANUARY 18, 19 83, that (I) (we) lost saw the deceased alive on JANUARY 18, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |                                                      |                                                                                                                                               |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                                                      | DEGREE                                                                                                                                        |                                                        |                                                                                   |  | 22c. DATE SIGNED                                                                                                        |   |                                   |   |          |   |   |
| CARL SPERLING MD                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |                                                      | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                        |                                                                                   |  | 1/18/83                                                                                                                 |   |                                   |   |          |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                      | 22e. ADDRESS                                                                                                                                  |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| CARL SPERLING, M.D.                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                      | 201 E. UNIVERSITY PKWY BALTO. MD. 21218                                                                                                       |                                                        |                                                                                   |  |                                                                                                                         |   |                                   |   |          |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 23b. DATE                                                                                                                                                |                                                      | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                            |                                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE                                           |  |                                                                                                                         |   |                                   |   |          |   |   |
| BURIAL                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 1/21/83                                                                                                                                                  |                                                      | BALTIMORE                                                                                                                                     |                                                        | BALTIMORE, MD.                                                                    |  |                                                                                                                         |   |                                   |   |          |   |   |
| 24. FUNERAL HOME NAME                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                      | 25a. DATE REC'D. BY REGISTRAR                                                                                                                 |                                                        | 25b. REGISTRAR'S SIGNATURE                                                        |  |                                                                                                                         |   |                                   |   |          |   |   |
| SCHUMUNK FUNERAL HOME, INC. 3331 BREHMS LANE, BALTO. MD. 21213                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                                                      | JAN 21 1983                                                                                                                                   |                                                        | John S. A                                                                         |  |                                                                                                                         |   |                                   |   |          |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 8 3 0 0 8 0 4                                                                                                                                            |  |                                                                                                                         |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DALGREN B CONTE</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>1 7 83 7:38 PM</b>                                                                                       |  |                                                                                                                         |                                              |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>W</b>                                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 28 96</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>86</b> YRS. MONTHS DAYS HOURS MIN.               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                                                      |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                      |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>J. Louis Bradley</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Ferrcindin</b>                                                                                |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-6985</b>                                                                                                           |  | 17. INFORMANT ADDRESS<br><b>Mr. Jack Dunn 714 Milldam Rd. 21204</b>                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5140 IMMEDIATE CAUSE (a) Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE GI BLEED. / PULMONARY EDEMA.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Edema.</b>                                                             |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                 |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>STREET</b>                                                                                                 |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/7/83</b> , 19 <b>83</b> , to <b>1/7/</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>P. Kennedy MD.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | DEGREE<br><b>MD.</b>                                                                                                                                     |  | 22c. DATE SIGNED<br><b>1/7/83</b>                                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER KENNEDY</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP</b>                                                                                                               |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>1/10/83</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemt.</b>                                                                                        |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cockeysville Md.</b>                                                      |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | 24b. ADDRESS<br><b>6500 York Rd.</b>                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 17 1983 John J. Connel</b>                           |                                              |

DATE: 1/23/88

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]



[illegible text]

CONFIDENTIAL - SECURITY INFORMATION

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300805

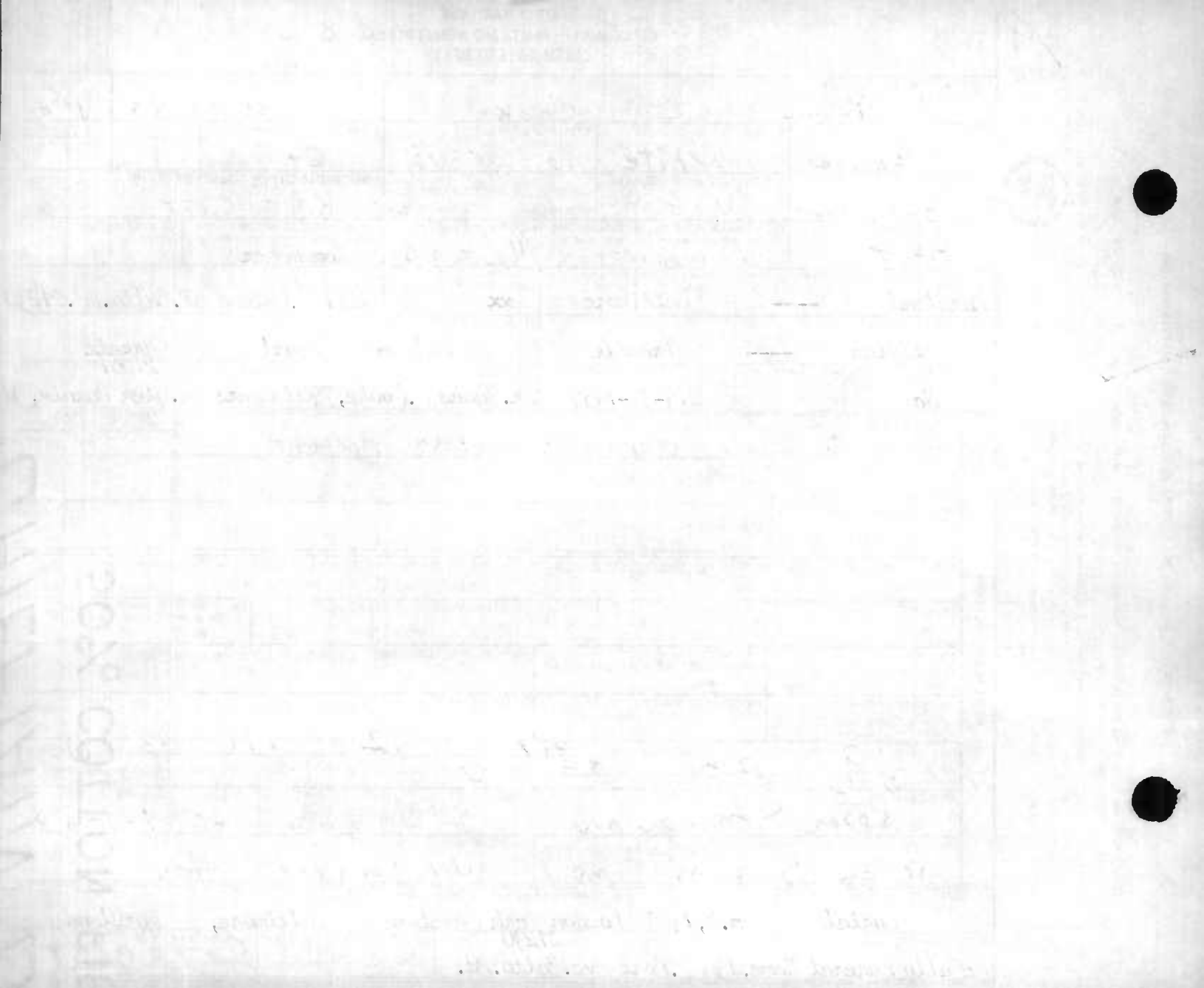
1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                                               |                                                                                                                                                             |                                                                                        |                                                                                      |                                                                   |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEARL C. COOKE</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 01 83</b>                        |                                                                                                                                                             |                                                                                        | 2b. HOUR<br><b>105 AM</b>                                                            |                                                                   |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                                    |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 05 - 18</b>                                                                                                   |                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    |                                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.                         |                                                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b> |                                                                               |                                                                                                                                                             |                                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            | 13b. COUNTY<br><b>---</b>                                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                  |                                                                                      | 13d. STREET ADDRESS<br><b>1211 W. Ostend St. Balto. Md. 21230</b> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William --- Trostle</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mildred Pearl Garrett</b> |                                                                                                                                                             |                                                                                        | ADDRESS<br><b>21061</b>                                                              |                                                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>215-30-1459</b>                                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mr. James C. Cooke, 7908 Myers Dr. Glen Burnie, Md.</b> |                                                                                      |                                                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                            |                                                                               |                                                                                                                                                             |                                                                                        |                                                                                      |                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                 |  |                                                                                                                                            |                                                                               |                                                                                                                                                             |                                                                                        |                                                                                      |                                                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                             |                                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:12 P.M. 19 82</b>     |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)          |                                                                                      |                                                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |                                                                                      |                                                                   |                                                                                                                            |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>7/12 19 82</b> to <b>1/1 19 83</b> , that (b) (we) lost saw the deceased alive on <b>12/31 19 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                               |  |                                                                                                                                            |                                                                               |                                                                                                                                                             |                                                                                        |                                                                                      |                                                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Peter Stamas MD</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                                               |                                                                                                                                                             |                                                                                        | DEGREE<br><b>MD</b>                                                                  |                                                                   | 22c. DATE SIGNED<br><b>1-1-83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER STAMAS MD</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            | 22e. ADDRESS<br><b>UNIVERSITY HOSP.</b>                                       |                                                                                                                                                             |                                                                                        |                                                                                      |                                                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>Jan. 4, 1983</b>                                                                                                           |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                           |                                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |                                                                   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McMully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                                               | ADDRESS<br><b>21230</b>                                                                                                                                     |                                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1983</b>                                   |                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Givier</b>                                                                        |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

68061306

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                 |                                               |                                                                                                                                                             |                                                                  |                                                                                                 |                                                        |                                   |  |
|---------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Cleopaus G Cooper</b>                    |                                               |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/4/83</b>                   |                                                                                                 |                                                        | 2b. HOUR <b>0630A</b>             |  |
| 3. SEX<br><b>m</b>                                                              | 4. RACE<br><b>N</b>                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 9 19</b>                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD |                                                                                                 |                                                        |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                   |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b>                      |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                        | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br><b>Maryland</b>                                                   |                                               | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>126 S. Culver St. #21229</b> |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Cooper</b>                  |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Chaney Goldberg</b>                                                                                     |                                                                  |                                                                                                 |                                                        |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> |                                               | 16b. SOCIAL SECURITY NO.<br><b>229-16-8411</b>                                                                                                              |                                                                  | 17. INFORMANT ADDRESS<br><b>Jessie B. Cooper 126 S. Culver Street</b>                           |                                                        |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cerebrovascular accident**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**< 24 hr.****4360**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cerebral aneurysm (Atherosclerosis stroke)**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Hypertension**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                                                      |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                        |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>83</b> , to <b>1/4</b> , 19 <b>83</b> , that (I) (we) last<br>saw the deceased alive on <b>1/4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>W. Kramer</b>                                                                                                                                                                                                                                                                                                                                    |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1/4/83</b>                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORTON D. KRAMER, M.D.</b>                                                                                                                                                                                                                                                                                                |                                                                        | 22e. ADDRESS<br><b>900 Caton Ave. Balto. Md. #21229</b>                                                                                              |                                                                                                                               |

|                                                                                   |                            |                                                               |                                                                      |
|-----------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                  | 23b. DATE<br><b>1/8/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gough</b>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH PRELIMINARY RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  | REG. NO. 00807                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RAY GARY COOPER</b>                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>1 3 1983</b>                        |  |
| 1. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 5 29</b>                                                                             | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>53</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>1 3</b>                                                                                                                 | IF UNDER 24 HRS.<br>HOURS MIN<br><b>1 3</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 3 1983</b>                                                        |  | 2d. HOUR<br><b>0935</b>                               |  |                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                     |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b>                                                           |  |                                                       |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Center St.</b> |                                                      |                                                                                                                                                             |                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |                                                                                     |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 13b. COUNTY<br><b>Balto.</b>                                                                                                    |                                                      | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 13e. STREET ADDRESS<br><b>8026 Penwood Ave. 21219</b> |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carl T. Cooper</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maisie Olen Kyle</b>                                                        |                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                              |                                             | 16b. SOCIAL SECURITY NO.                                                                                             |  | 17. INFORMANT<br>ADDRESS<br><b>Balto., Md. 21219</b>  |  |                                                                                     |  |
| 16c. MRS. MAISIE COOPER                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 8026 Penwood Ave.                                                                                                               |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exposure to cold</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic alcoholism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3030</b>                                                                                                                                                             |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                 |                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                             |                                                                                                                      |  |                                                       |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                 |                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>1 3 1983</b>                                                                                     |                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Full asleep in exposed place</b> |  |                                                       |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                 |                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Stamwell</b>                                                                              |                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Shipping Place at Center St. Balto., Md. 21222</b>           |  |                                                       |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             |                                                                                                                      |  |                                                       |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><b>J. Crossan O'Donovan</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                 |                                                      | TITLE (SPECIFY)<br><b>Deputy</b>                                                                                                                            |                                             |                                                                                                                      |  | DATE SIGNED<br><b>1/3/83</b>                          |  |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>J. CROSSAN O'DONOVAN</b>                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                 |                                                      | ADDRESS<br><b>2112 Dundalk Ave. Balto., Md. 21222</b>                                                                                                       |                                             |                                                                                                                      |  |                                                       |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                 |                                                      | 23b. DATE<br><b>1/3/83</b>                                                                                                                                  |                                             | 23c. NAME OF CEMETERY OR CREMATORY                                                                                   |  |                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Anatomy Board Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                 |                                                      |                                                                                                                                                             |                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>                                                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b> |  |                                                                                     |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 0 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                            |                                                                                                                                   |                                                                                                                                                             |                                                                                  |                                |                                                                                                 |                     |                                |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------|---------------------|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lucy Emily Copinger |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 10 83                                   |                                |                                                                                                 | 2b. HOUR<br>8 30 AM |                                |
| 3. SEX<br>Female                                           | 4. RACE<br>White                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 20 1883                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.                                       |                                | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                  |                     | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S.A.                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |                                |                                                                                                 |                     |                                |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Proof Reader |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>B.G.&E.                                                    |                     |                                |
| 13a. STATE<br>Maryland                                     |                                                                                                                                   |                                                                                                                                                             | 13b. COUNTY                                                                      | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |                                |
| 13e. STREET ADDRESS<br>Lochwood Rd 21239                   |                                                                                                                                   |                                                                                                                                                             |                                                                                  |                                |                                                                                                 |                     |                                |

|                                                                                                      |  |                                         |                                                           |                                                                 |  |
|------------------------------------------------------------------------------------------------------|--|-----------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Louis Copinger                                     |  |                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary May |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>No |  | 16b. SOCIAL SECURITY NO.<br>212-05-6172 |                                                           | 17. INFORMANT<br>ADDRESS<br>R.B.Copinger 6902 Avondale Rd 21212 |  |

|                                                                                                                                                                                                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4370 IMMEDIATE CAUSE (a) Cerebral Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                                                                                                                                                                                     |  |

|                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from Aug 22 19 79 to Jan 10 19 83, that (we) last saw the deceased alive on Jan 10 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                                              |  | DEGREE<br>MD                                                           |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/10/83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br>700 W. 40th St., Balto 21211                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                           |  | 23b. DATE<br>1-12-83                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Baltimore Maryland                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Rd 21212                                                                                                                                                                                                                                       |  |                                                                        |  | 25a. DATE REC'D. BY REGISTRAR (IN REGISTRAR'S SIGNATURE)<br>JAN 17 1983                                                                    |  |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11.

251

1176

951

515

6. *i* *in* *i*

Leifon



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

00809

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                               |                                                                                                                                                |                                                                                                                                                             |                                                                           |                                       |                                                                                                 |
|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LOUISE CORBETT</b>                                                  |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 02, 1983</b>            |                                       | 2b. HOUR<br><b>01:0AM</b>                                                                       |
| 3. SEX<br><b>Female</b>                                                                                       | 4. RACE<br><b>Black</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 12 19</b>                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                         |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.         |                                       |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. STATE<br><b>Maryland</b>                                                                                 |                                                                                                                                                |                                                                                                                                                             | 13b. COUNTY                                                               | 13c. CITY OR TOWN<br><b>Baltimore</b> | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Billy Conner</b>                                                 |                                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Butts</b>         |                                       |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>231-22-0203</b>                                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Robert Conner 2323 Pennsylvania Avenue</b> |                                       |                                                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1579

IMMEDIATE CAUSE (a) **cardiac standstill**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.(b) **pancreatic cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

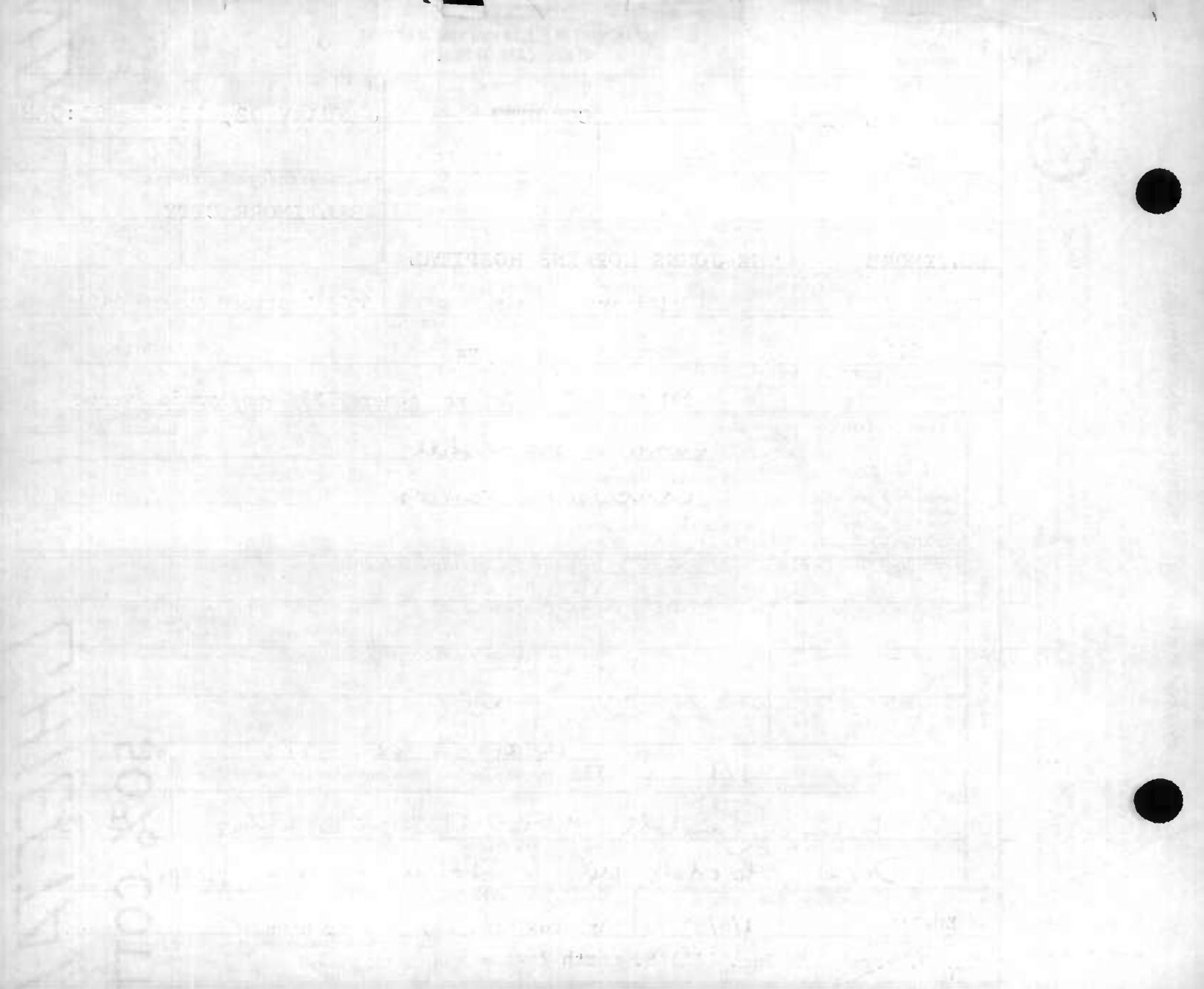
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                                            |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET                                                                                                                    | CITY OR TOWN COUNTY STATE                                                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>82</b> , to <b>1/2</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                               |
| 22b. SIGNATURE<br><b>Drew Pardoll</b>                                                                                                                                                                                                                                                                                                                                   | DEGREE<br><b>MD PhD</b>                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>1/2/83</b>                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Drew Pardoll MD</b>                                                                                                                                                                                                                                                                                                         |                                                                        | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                              |                                                                                                                               |

|                                                                    |                            |                                                                                                  |                                                                  |
|--------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>      | 23b. DATE<br><b>1/6/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b> |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H Inc. 1101 E. north Avenue |                            | 25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b> |                                                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                   |  | REG. NO. 83 00810                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Herman Cornish, Jr.</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 5, 1983</b>                                                                                        |                                                                                         | 2b. HOUR<br><b>5:12P<sub>M</sub></b>                                                            |                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Black</b>                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 4 1923</b>                                                                                                   |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                        |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |                                                                                                 |                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>            |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                    |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br><b>2018 Linden Ave. 21217</b>                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herman Cornish, Sr.</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara F. Davis</b> |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>220 01 3345</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Theresa Cornish 2018 Linden Avenue</b>                                                                           |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>                                                                                                                                                                                       |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sepsis</b>                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 | <b>3 days</b>                                                                                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Right Lung Squamous Cell Carcinoma</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Metastatic Carcinoma to Brain</b>                                                                                                                                                                             |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      |                                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>November 1, 1983</b> to <b>January 5, 1983</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>January 5, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>1/5/83</b>                               |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE AND PRINT)<br><b>Stephen J. O'Connell, M.D.</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>                                                                                                 |                                                                                         |                                                                                                 |                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 23b. DATE<br><b>1/10/83</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>                                                                                                 |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO Md.</b>                                  |                                                                 |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons 1701 Laurens Street</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 - 1983</b>                                                                                                 |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                |                                                                 |                                                                                                                            |  |



CHIEF

20% 201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 1 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                           |                                                                                                 |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Cornish</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 22 83</b> |                                                                                                                                                             |                                                                           | 2b. HOUR<br>M<br><b>1</b>                                                                       |                                                                                                                            |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                  |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 10 15</b>                                                                                                        |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                               |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                               |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>836 Washington Blvd.</b> |                                                       |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Cornish</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva</b>                                                                                                 |                                                                           |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-6553</b>                                                                                           |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Nellie M. Cornish 836 Washington Blvd.</b>                                                                                   |                                                                           |                                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>ASCOR.</b> |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>1 hr</b><br><b>YEAR</b>                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                           |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                        |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                           |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>12/19 80</b>                                                |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1/22 83</b>                                                                                         |                                                                           |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-18-83</b> to <b>1/22</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-18-83</b> above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                  |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                           |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Dr. Arum</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |                                                       | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                           | 22c. DATE SIGNED<br><b>1/25/83</b>                                                              |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL F. ARUM</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                       | 22e. ADDRESS<br><b>7540 W. Belts St Balto Md 21223</b>                                                                                                      |                                                                           |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SP) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>1/27/83</b>                                                                                                              |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem.</b>                                                                                             |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>                          |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                             |                                                                                                                            |  |

MEDICAL CERTIFICATION

RECEIVED  
FEB 11 1910



WILEY

30% COLLEGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                  |  | 8 3 0 0 8 1 2                                                                                                                                               |  |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                  |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RICHARD ANTHONY CORTIMILIA</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>21</b> YEAR <b>83</b>                                                                                            |  | 2b. HOUR<br><b>12:25 PM</b>                                                                                                |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                          |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>1933</b>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UAMC LOCH RAVEN BLVD. BALTO MD</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Commerice Artist</b>                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Art</b>                                                                            |                                              |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Towson</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS <b>4 Ecoway Court</b> 21204                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST <b>Anthony</b> MIDDLE <b>Cortimilia</b> LAST <b>Anthony</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>                                                                     |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WWII</b> <b>269 30 0371</b>           |  | 17. INFORMANT<br>ADDRESS <b>Betty L. Cortimilia Same</b>                                                                                                    |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DISSEMINATED PANCREATIC CARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____                                               |  |                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                                       |  |                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br><b>1/4/83</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PANCREATIC MASS</b>                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>October 26</b> , 19 <b>82</b> , to <b>January 21</b> , 19 <b>83</b> , that <del>(X)</del> (we) lost saw the deceased alive on <b>January 21</b> , 19 <b>83</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I/we)</del> (did) (do not) view the body after death. |  |                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>C. D. Cousar MD</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/21/83</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. D. COUSAR</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md 21218</b>                                                                                                |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>1/24/1983</b>                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Cemetery</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN <b>Parkville</b> COUNTY <b>Balto</b> STATE <b>Md</b>                                         |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |  |                                                                                                                            |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                  |  | ADDRESS<br><b>6500 York Rd.</b>                                                                                                                             |  |                                                                                                                            |                                              |





20% COTTON FIBER

THE ALL-STATE COTTON FIBER CO. NEW YORK, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                       |                                                                                | 8 3 0 0 8 1 3<br>REG. NO.                                                                       |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Thomas Cosgrove                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 7, 1983                            |                                                                                                 | 2b. HOUR<br>M                                                                                                              |
| 3 SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4 RACE<br>white                                                                                                                 | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>August 31, 1920                                                                                                       |                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                        |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY<br>warehouse                                                  |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 | 13b. COUNTY<br>Baltimore                                                                                                                                   | 13c. CITY OR TOWN<br>Baltimore                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1168 Nanticoke Street 21230                                                                         |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Martin Cosgrove                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Abel                                                                                                  |                                                                                |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW2                                                                                             | 17 INFORMANT ADDRESS<br>Barbara Lindamood 4722 Brittany Drive 21043            |                                                                                                 |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>4100 IMMEDIATE CAUSE (a) Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Arteriosclerotic coronary artery disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>immediate years |                                                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                                                                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                       |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22 I certify that (I) (this hospital) attended the deceased from 10/4, 1976, to 1/7/83, 19____, that (I) (we) last saw the deceased alive on 1/3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                               |                                                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>Laurence R. Gallagher                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                 | DEGREE<br>MD                                                                                                                                               |                                                                                | 22c. DATE SIGNED<br>1/7/83                                                                      |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurence R. Gallagher, M.D.                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                 | 22e. ADDRESS<br>3455 Wilkens Avenue Balto. Md. 21229                                                                                                       |                                                                                |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial                                                                                                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br>1/10/83                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery                                                                                                 |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland                            |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                 | ADDRESS<br>1328 Sulphur Spring Rd.                                                                                                                         |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>1 JAN 7 1983<br>25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |                                                                                                                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 8 3 0 0 8 1 4                                                                                                                       |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Malcolm Earl Cottrell                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 9, 1983                                                                                                         |  | 2b. HOUR<br>12:45AM                                                                                                                        |  |                                                                                                                         |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>Black                                                                                                                    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 25 21                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                                                                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                  |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br>BALTIMORE                                                                                                            |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13d. STREET ADDRESS<br>1726 N. Carey St. 21217                                                                                             |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Porter Cottrell                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maggie Starvis                                                                                                |  |                                                                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>224-14-2646                                                                                             |  | 17. INFORMANT ADDRESS<br>Doretha Watts 1726 N. Carey St.                                                                                                    |  |                                                                                                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septic Shock<br>5070<br>DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>About 5 Hours<br>About 5 Hours |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)<br>Adeno Squamous Cell, Carcinoma of Lungs                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December 22, 1982, to January 9, 1983, that (we) lost the deceased alive on January 9, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.                                                                                                                   |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>Mary Smathers MD                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  | DEGREE<br>MD                                                                                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1-9-83                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mary Smathers, M.D.                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |  |                                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>1/14/83                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garden of Eternal Hope Westminster                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>MD                                                                                              |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 10 1983                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                               |  |                                                                                                                         |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                          |  |                      |                                                                                                                                  |                                                                 |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 | REG. NO. 00815                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS EDWARD Cox</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                      |                                                                                                                                  |                                                                 |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>1 23 1983</b> |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE <b>Black</b> |                                                                                                                                  | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>27</b> YEAR <b>09 73</b> |                                                                                      | 6. AGE (IN YEARS) LAST BIRTHDAY <b>73</b> YRS.                                                                                                           |                                                                                              | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |                                                                 | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                          |                                                                 |                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              |                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b> |                                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3407 Dennlyn Road</b> |                                                                 |                                                                                      |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Afro American</b>           |                                                                              |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                             |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                      | 13b. COUNTY                                                                                                                      |                                                                 | 13c. CITY OR TOWN <b>Balto.</b>                                                      |                                                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                              | 13e. STREET ADDRESS <b>3407 Dennlyn Rd. 21215</b>               |                                                                                                                                               |  |
| 14. FATHER'S NAME FIRST <b>Jessie</b> MIDDLE <b>Cox</b> LAST <b>Cox</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                      |                                                                                                                                  |                                                                 | 15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b>Taylor</b> LAST <b>Taylor</b> |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                      |                                                                                                                                  |                                                                 | 16b. SOCIAL SECURITY NO.                                                             |                                                                                                                                                          | 17. INFORMANT ADDRESS <b>Angela Franze 2316 W. Mosher St. 21216</b>                          |                                                                              |                                                                 |                                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                      |                                                                                                                                  |                                                                 |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                               |  |                      |                                                                                                                                  |                                                                 |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?               |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                              |  |                      |                                                                                                                                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>     |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)     |                                                                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |                                                                                                                                  |                                                                 |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                      |                                                                                                                                  | TITLE (SPECIFY) <b>Assistant</b>                                |                                                                                      |                                                                                                                                                          |                                                                                              | MEDICAL EXAMINER                                                             |                                                                 |                                                                                                                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                      |                                                                                                                                  | ADDRESS <b>111 Penn Street</b>                                  |                                                                                      |                                                                                                                                                          |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                      |                                                                                                                                  | 23b. DATE <b>1/28/83</b>                                        |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>                                                                                           |                                                                                              |                                                                              |                                                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>                                                                                    |  |
| 24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett</b> ADDRESS <b>4600 Liberty Hgts. Ave.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                  |                                                                 |                                                                                      | 25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1983</b> REGISTRAR'S SIGNATURE <i>John J. Connel</i>                                                             |                                                                                              |                                                                              |                                                                 |                                                                                                                                               |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |                  | FIRST<br>ADRIAN                                                                                                                         |  | MIDDLE<br>F.                                                                                                                                                |  | LAST<br>CRAWLEY                                                                                 |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1-5-83<br>19 |  | 2b. HOUR<br>M<br>6:11PM<br>M                                                        |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>col r | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-16-1958                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>24 YRS.                                                                                                                  |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                   |  | IF UNDER 24 HRS.<br>HOURS MIN                                          |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1-5-83<br>19                          |  |
| 7a. BIRTHPLACE (STATE OR TERRITORY)<br>Balt. Md                                                                                                                                                                                                                                                                                                                                                                                          |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                                                                        |  |                                                                                     |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3405 Cedardale (basement) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                 |  |                                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13b. COUNTY                                                                                                                             |  | 13c. CITY OR TOWN<br>Balt.                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5303 Eastbury Ave. 21206                        |  |                                                                                     |  |
| 14. FATHER'S NAME<br>Theodore                                                                                                                                                                                                                                                                                                                                                                                                            |                  | MIDDLE                                                                                                                                  |  | LAST<br>Crawley                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>Edith Reid                                                          |  | MIDDLE                                                                 |  | LAST                                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                              |                  | (IF YES, GIVE WAR OR DATES)                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>214-68-0679                                                                                                                     |  | 17. INFORMANT<br>Mr. Theodore                                                                   |  | ADDRESS<br>Crawley 3405 Cedardale Rd                                   |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shotgun wound of chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                     |                  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                       |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |                  | between 6:00 & 6PM<br>HOUR A.M. MONTH DAY YEAR<br>1-5-83                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self/inflicted                                                             |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>basement                                                                 |  | 21f. LOCATION<br>STREET<br>3405 Cedardale                                                                                                                   |  | CITY OR TOWN<br>Baltimore,                                                                      |  | COUNTY<br>Maryland                                                     |  | STATE                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
| ACTUAL SIGNATURE<br>H. R. Guard                                                                                                                                                                                                                                                                                                                                                                                                          |                  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                       |  | MEDICAL EXAMINER                                                                                                                                            |  |                                                                                                 |  | DATE SIGNED<br>1-6-83                                                  |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                  | Hormez R. Guard, M.D.                                                                                                                   |  | ADDRESS<br>111 Penn Street                                                                                                                                  |  |                                                                                                 |  |                                                                        |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)                                                                                                                                                                                                                                                                                                                                                                                                |                  | 23b. DATE<br>1-10-83                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore                                                      |  | COUNTY<br>Md                                                           |  | STATE                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                             |                  | Joseph L. Russ                                                                                                                          |  | ADDRESS<br>2222 W. North Ave.                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lammie                           |  |                                                                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 there is any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | 8300817  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| FOR<br>1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELEANOR E. CREEL</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-17-83</b>                                           |  | 2b. HOUR<br><b>7<sup>30</sup> AM</b>                                                                                       |  |          |  |
| 3 SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>W</b>                                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-31-23</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |                                                                                                                            |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3420 Noble Street -21224</b>                                                                     |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Yoder</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Savage</b>                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>203-14-6821</b>                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Barbara J. Wlodarski - 5716 Cedella Ave. 21206</b>                                                                              |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>                                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 MIN</b>                                                              |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                             |  |          |  |
|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  | (b) <b>PULMONARY HEMORRHAGE</b>                                                                                            |  |          |  |
|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  | (c) <b>EPIDERMAL CARCINOMA OF LUNG</b>                                                                                     |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NONE</b>                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>17 JAN 83</b> to <b>ONLY</b> 19____, that (1) (we) last saw the deceased alive on <b>NEVER</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did (did not) view the body after death. |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 22b. SIGNATURE<br><b>Dale C Kephart MD</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>17 Jan 1983</b>                                                                                     |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DALE C KEPHART</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITAL</b>                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>1-20-83</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |                                                                                                                            |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | ADDRESS                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |          |  |

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Let's go to the next slide.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 0 8 1 8<br>CERTIFICATE OF DEATH                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                 |  |                              | REG. NO.                                                                                               |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  |                              | FIRST MIDDLE LAST                                                                                      |                                                                                                                                                          |                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR                                       |                                              |                                                                                                                         | 2b. HOUR                                                                          |
| Rose                                                                                                                                                                                                                                                                                                   |  |                              | Cremer                                                                                                 |                                                                                                                                                          |                                                                                | 1-6-83                                                                 |                                              |                                                                                                                         | 2 <sup>20</sup> A M                                                               |
| 3. SEX                                                                                                                                                                                                                                                                                                 |  | 4. RACE                      |                                                                                                        | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)                                        |                                              | IF UNDER 1 YEAR IF UNDER 24 HRS                                                                                         |                                                                                   |
| F                                                                                                                                                                                                                                                                                                      |  | White                        |                                                                                                        | 6 10 21                                                                                                                                                  |                                                                                | 61 YRS                                                                 |                                              | MONTHS DAYS HOURS MIN                                                                                                   |                                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |                                              |                                                                                                                         |                                                                                   |
| Tenn.                                                                                                                                                                                                                                                                                                  |  | USA                          |                                                                                                        |                                                                                                                                                          |                                                                                | Baltimore MD.                                                          |                                              |                                                                                                                         |                                                                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                                                                   |
| Baltimore                                                                                                                                                                                                                                                                                              |  |                              | Montebello Center                                                                                      |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                             |  |                              |                                                                                                        |                                                                                                                                                          | 13b. COUNTY                                                                    |                                                                        | 13c. CITY OR TOWN                            |                                                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Md                                                                                                                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          | Baltimore                                                                      |                                                                        | 833 W. Pratt St.                             |                                                                                                                         | 21201                                                                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                    |  |                              |                                                                                                        |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                     |                                                                        |                                              |                                                                                                                         |                                                                                   |
| John Bullington                                                                                                                                                                                                                                                                                        |  |                              |                                                                                                        |                                                                                                                                                          | Daisy Chambers                                                                 |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                      |  |                              |                                                                                                        |                                                                                                                                                          | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                           |                                                                        | 17. INFORMANT ADDRESS                        |                                                                                                                         |                                                                                   |
| NO                                                                                                                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          | 264-16-7831                                                                    |                                                                        | Charles Bullington Nash, Tenn 505 Landon Dr. |                                                                                                                         |                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                               |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                           |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 1749 IMMEDIATE CAUSE (a) Cardiopulmonary arrest                                                                                                                                                                                                                                                        |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer                                                                                                                                                                                                                                            |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                    |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                          |                                                                                | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                        |                                              |                                                                                                                         |                                                                                   |
|                                                                                                                                                                                                                                                                                                        |  |                              | P.M. 19                                                                                                |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                               |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                        |                                              |                                                                                                                         |                                                                                   |
|                                                                                                                                                                                                                                                                                                        |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-21, 1982, to 1-6, 1983, that (I) (we) lost the deceased alive on 1-6-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 22b. SIGNATURE DEGREE                                                                                                                                                                                                                                                                                  |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              | 22c. DATE SIGNED                                                                                                        |                                                                                   |
| Howard Freeland MD                                                                                                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          |                                                                                |                                                                        |                                              | 1-6-83                                                                                                                  |                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |  |                              |                                                                                                        |                                                                                                                                                          | 22e. ADDRESS                                                                   |                                                                        |                                              |                                                                                                                         |                                                                                   |
| Howard Freeland MD                                                                                                                                                                                                                                                                                     |  |                              |                                                                                                        |                                                                                                                                                          | Montebello Center                                                              |                                                                        |                                              |                                                                                                                         |                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                              |  |                              | 23b. DATE                                                                                              |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE      |                                                                                                                         |                                                                                   |
| Cremation                                                                                                                                                                                                                                                                                              |  |                              | 1/7/83                                                                                                 |                                                                                                                                                          | Westview Mem. Pk.                                                              |                                                                        | Catonsville, Md.                             |                                                                                                                         |                                                                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                              |  |                              |                                                                                                        |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                        | 25b. REGISTRAR'S SIGNATURE                   |                                                                                                                         |                                                                                   |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                      |  |                              |                                                                                                        |                                                                                                                                                          | JAN 7 1983                                                                     |                                                                        | John J. Canine                               |                                                                                                                         |                                                                                   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

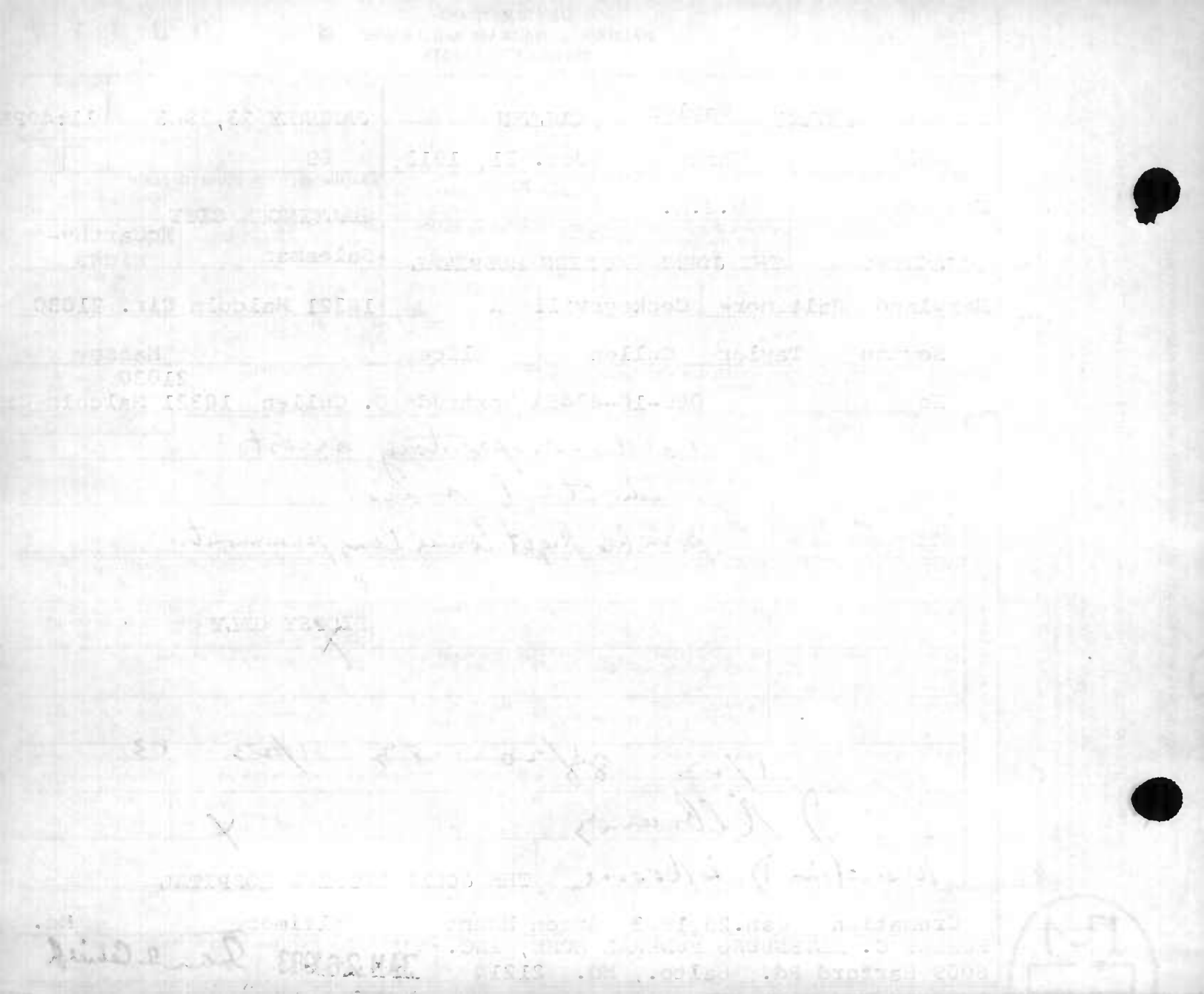
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |  | 8 3 0 0 8 1 9                                                                                                                                               |  |                                                                                                                                |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NEWTON Taylor CULLEN</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 23, 1983</b>                                                                                                    |  |                                                                                                                                |                                                 |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  | 2b. HOUR <b>11:40 PM</b>                                                                                                                                    |  |                                                                                                                                |                                                 |
| 4. RACE <b>White</b>                                                                                                                                                                                                                                                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 31, 1913</b>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                              |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hicks</b>                                                                              |                                                 |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                      |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Newton Taylor Cullen</b>                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Allice Massey</b>                                                                                |  | 13e. STREET ADDRESS<br><b>10321 Malcolm Cir. 21030</b>                                                                                                      |  |                                                                                                                                |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>089-10-4945A</b>                                                                                                      |  | 17. INFORMANT<br>ADDRESS<br><b>Gertrude G. Cullen, 10321 Malcolm Cir.</b>                                                                                   |  |                                                                                                                                |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>medastinal mass.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>possible right lower lung pneumonia</b>                                        |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                                       |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br><b>BLOPSY ONLY</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (GIVEN NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> , 19 <b>83</b> , to <b>1/23</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                |                                                 |
| 22b. SIGNATURE<br><b>Marcelina D. Albuerne</b>                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                                                            |  |                                                                                                                                |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marcelina D. Albuerne</b>                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                                |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>Jan. 25, 1983</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                             |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br/>6009 Harford Rd., Balto., Md. 21214</b>                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                                                         |                                                 |

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | REG. NO. 00820                                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CLYDE (CYLDE) G. (CUMMINS) CUMMINGS                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR<br>1-30-83                                                                                                           |  |
| 3. SEX Male 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 10 3 13 6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-30-83 3:21P                                                                                                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2405 E. Hoffman Street 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                         |  |  |  |  |  |  |  |  |  | 13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Cummings 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 17. SOCIAL SECURITY NO. 213-10-9969 18. INFORMANT ADDRESS Hattie O. Cummings 2405 E. Hoffman |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF                                                                                             |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-31-83                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. ADDRESS 111 Penn Street                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2/5/83 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. 25a. DATE REC'D. BY REGISTRAR FEB 1 1983 25b. REGISTRAR'S SIGNATURE [Signature]                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                                   |  |

RECEIVED  
JAN 17 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 8 3 0 0 8 2 1                                                                                                                                               |  |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| I. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 2a. DATE OF DEATH                                                                                                                                           |  |                                                                                                                            |                                              |
| FIRST MIDDLE LAST<br><b>PLUMIE CURBEAM</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | MONTH DAY YEAR<br><b>JANUARY 21 1983</b>                                                                                                                    |  |                                                                                                                            |                                              |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 2b. HOUR<br><b>10:45 AM</b>                                                                                                                                 |  |                                                                                                                            |                                              |
| 4. RACE<br><b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 7 1894</b>                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                            |                                              |
| 13a. STATE<br><b>Ma</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13e. STREET ADDRESS<br><b>1814 N. Wolfe Street</b>                                                                         |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sampson Brice</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mealy</b>                                                                                               |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                   |  | 17. INFORMANT ADDRESS<br><b>Plumie Davis 1814 N. Wolfe Street</b>                                                                                           |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBROVASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>83</b> to <b>1/21</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>1/21/83</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. IMRAGLIATELLI, M.D.</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MD. 21231</b>                                                                 |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>1/27/82</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olive</b>                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Black Stock S. C.</b>                                                     |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F/H 1101 E. North Ave</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 24 1983</b> <i>[Signature]</i>                                                           |  |                                                                                                                            |                                              |

MEDICAL CERTIFICATION

BP

18  
(M)



2008 COLLECTION

(15)

1818

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |              |  |                                                                                                                                       |  |                                                                  |  |                                                                                                                                                             |  | REG. NO. 3-00822                                                                                     |  |                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FRANKLIN O'NEILL CURTIS                                                                                                                                                                                                                                                                                                                                                                      |  |              |  |                                                                                                                                       |  |                                                                  |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 9 19 83 |  | 2b. HOUR<br>M<br>4:03 P M                                                                                           |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/29/06                                                                                         |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS.                    |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 9 19 83                                              |  | 2d. HOUR<br>P M                                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. J.                                                                                                                                                                                                                                                                                                                                                                                                    |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  |                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                            |  |                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |                                                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive                                                                                  |  |                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance                                                                      |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                |  |              |  | 13b. COUNTY                                                                                                                           |  | 13c. CITY OR TOWN<br>Baltimore                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>30 York Ct. 21218                                                             |  |                                                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dr. E. M. Curtis                                                                                                                                                                                                                                                                                                                                                                                            |  |              |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche O'Neill |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                           |  |              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 01 0893                                                                |  | 17. INFORMANT ADDRESS<br>Mrs. Gladys P. Curtis, Same             |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration of food</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                              |  |              |  |                                                                                                                                       |  |                                                                  |  |                                                                                                                                                             |  |                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                   |  |              |  |                                                                                                                                       |  |                                                                  |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |  |                                                                  |  |                                                                                                                                                             |  |                                                                                                      |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 1-9- 19 83                                                                  |  |                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject aspirated food.                                                    |  |                                                                                                      |  |                                                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                             |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home                                                                   |  |                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>30 York Ct. Balto., Md.                                                                                |  |                                                                                                      |  |                                                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |              |  |                                                                                                                                       |  |                                                                  |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                               |  |              |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                                  |  |                                                                  |  | MEDICAL EXAMINER                                                                                                                                            |  |                                                                                                      |  | DATE SIGNED<br>1-10-83                                                                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |  |              |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                            |  |                                                                  |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                |  |              |  | 23b. DATE<br>1/11/83                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount                |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD                                             |  |                                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.                                                                                                                                                                                                                                                                                                                                                                                           |  |              |  |                                                                                                                                       |  |                                                                  |  | ADDRESS<br>4905 York Road Balto., MD 21212                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983                                                         |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

MEDICAL CERTIFICATION



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Executive

1919

New York Co.

x

Baltimore

W. J. H.

Omaha

Elmwood

Omaha

Mr. M. J.

Omaha

Mr. Gladys F. Curtis

1919-01-0820

No

MD

Elmwood

Green Mount

1919-01-0820

H. J. Curtis & Son Co.

York Road, Md. 2115



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 2 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Amelia Cecilia Dabrowka Dabrowka</i>                                                                                                                                                                                                                                                                                                 |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 30 83</i>                                                                                                       |                                                                                    | 2b. HOUR<br><i>125 PM</i>                                                            |                                                           |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><i>Cauc</i>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 28 14</i>                                                                                                        |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.                                    |                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |                                                           |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospitals</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Haschild-Kohn</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                       |                                                                                                                                           | 13b. CITY OR TOWN<br><i>Eastwood</i>                                                                                                                        | 13c. STREET ADDRESS<br><i>7107 Gough Street 21224</i>                              |                                                                                      |                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Markiewicz</i>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                                                                                    |                                                                                      |                                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><i>216-09-7745</i>                                                                                                              |                                                                                    | 17. INFORMANT<br>ADDRESS<br><i>Richard Dabrowka 7107 Gough Street 21224</i>          |                                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br><i>1629</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>adenocarcinoma of the lung</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                 |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      |                                                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                           |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                          |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      |                                                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                           |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                           |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                           |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-14-83</i> , 19 <i>83</i> , to <i>1-30-83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1-25-83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      |                                                           |
| 22b. SIGNATURE<br><i>Wm Russell</i>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                           | DEGREE<br><i>MD</i>                                                                                                                                         |                                                                                    | 22c. DATE SIGNED<br><i>1-30-83</i>                                                   |                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>William M. Russell</i>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                           | 22e. ADDRESS<br><i>Balt. City Hosp.</i>                                                                                                                     |                                                                                    |                                                                                      |                                                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                           | 23b. DATE<br><i>2-2-83</i>                                                                                                                                  |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>                       |                                                           |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Balto. Co., Md.</i>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           |                                                                                                                                                             |                                                                                    |                                                                                      |                                                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                           | ADDRESS<br><i>6224 Eastern Ave.</i>                                                                                                                         |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 1 1983</i>                                   |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>                                                                                                         |                                                                                    |                                                                                      |                                                           |

MEDICAL CERTIFICATION

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31  
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9  
1

BP

DHMH-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Female Pacific Bluebird

Female

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Belmont, Calif.

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Belmont, Calif.

Belmont, Calif. 11.11.11

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Belmont, Calif. 11.11.11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                           |                                                                             |                                                                                                 |                                                                        |                                                                                                                            | 8 3 0 0 8 2 4                                                               |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                           |                                                                             |                                                                                                 |                                                                        |                                                                                                                            | REG. NO.                                                                    |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE E. LAST DAUGHTON                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 23 83                                                                                                               |                                                                             |                                                                                                 |                                                                        | 2b. HOUR<br>P. M.                                                                                                          |                                                                             |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 3 92                                                                                                                   |                                                                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                  |                                                                                                 | 7. IF UNDER 1 YEAR MONTHS DAYS                                         |                                                                                                                            | 8. IF UNDER 24 HRS. HOURS MIN.                                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5220 York Road Apt 3P |                                                                     |                                                                                                                                                             |                                                                                                                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress |                                                                                                 |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                                                                                   |                                                                             |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                   |  |                                                                                                                                 | 13b. COUNTY                                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                            |                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                        | 13e. STREET ADDRESS<br>5220 York Road Apt. 3P 21212                                                                        |                                                                             |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN                                                                                                     |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>unknown                                 |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Helen Bassler 8423 Bay Road 21122                                                                                                |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarct</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                           |                                                                             |                                                                                                 |                                                                        |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>weeks</u><br><u>year</u> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>                                                                                                                                                                                                                                |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                           |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                                           |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |  |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                            |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                |  |                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                         |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>91</u> , to <u>1-23</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1-17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                           |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 22b. SIGNATURE<br><u>Reuben Hoffman</u>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                             |                                                                                                 | 22c. DATE SIGNED<br>1-24-83                                            |                                                                                                                            |                                                                             |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Reuben Hoffman                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br>846 W. 36th Street                                                                                                                        |                                                                             |                                                                                                 |                                                                        |                                                                                                                            |                                                                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 23b. DATE<br>1/26/83                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Pk.                                                                                                   |                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hillendale Baltimore Md. |                                                                                                                            |                                                                             |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | ADDRESS<br>4107 Wilkens Ave.                                                                                                                              |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983                                                    |                                                                        | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Calkins</u>                                                                       |                                                                             |  |  |  |

Hobbs, Ernest Home, Inc. 4107 Wilms Ave.

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H. J. ... ..

Dr. John Hoffman

845 W. 35th Street

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 8 3 0 0 8 2 5                                                                                                                                               |  |                                                                                                                                    |                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                    |                                                                   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALONZA NMI DAVIS</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01 13 83</b>                                                                                                         |  | 2b. HOUR<br><b>1:10 PM</b>                                                                                                         |                                                                   |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>BLACK</b>                                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 15 15</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>67</b>                                                           |                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                  |                                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                  |                                                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 13c. CITY OR TOWN<br><b>BALT. CITY</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                                                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JUNE NMI DAVIS</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ALBERTA GRIME</b>                                                                                          |  |                                                                                                                                    |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>240-90-1194</b>                                                                                                   |  | 17. INFORMANT ADDRESS<br><b>CHART.</b>                                                                                                                      |  |                                                                                                                                    |                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA OF THE COLON MANY YEARS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                    |                                                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                    |                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/7</b> , 19 <b>83</b> , to <b>1/13</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    |                                                                   |
| 22b. SIGNATURE<br><b>James J. Damalou</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/13/83</b>                                                                                                 |                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAMALOU</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 22e. ADDRESS<br><b>22 SOUTH GREENE ST. BALTO. MD.</b>                                                                                                       |  |                                                                                                                                    |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>1-19-83</b>                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN Cem.</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                                                                         |                                                                   |
| 24. FUNERAL DIRECTOR NAME<br><b>BROWN-Thompson F.H.</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                                                                                         |  |                                                                                                                                    |                                                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    |                                                                   |



1917



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                   |                                                                                                                                          |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                 |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth</b><br>(ELISABETH) <b>DAVIS</b>  |                                                                                                                                          |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 16, 1983</b>      |                                                                                                 | 2b. HOUR<br><b>1:58AM</b>                                       |
| 3. SEX<br><b>Female</b>                                                           | 4. RACE<br><b>Black</b>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 29 35</b>                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b>                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>Maryland</b>                                                     |                                                                                                                                          | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee Harris</b>                       |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Olla Cole</b>                                                                                      |                                                                  |                                                                                                 |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                                       |                                                                  | 17. INFORMANT ADDRESS<br><b>Joyce Hargrove 200 N. Aisquith St.</b>                              |                                                                 |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CORONARY HEART DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **4140**

|                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                              |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)               |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                            |                                                                                                                            |
| 22a. I certify that (1) this hospital attended the deceased from <b>JAN. 16, 1983</b> , to <b>JAN. 16, 1983</b> , that (1) (we) last saw the deceased alive on <b>JAN. 16, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |                                                                        |                                                                                              |                                                                                                                            |
| 22b. SIGNATURE<br><i>Bernard Yukna</i>                                                                                                                                                                                                                                                                                                         | DEGREE<br><b>MD</b>                                                    | 22c. DATE SIGNED<br><b>ER 16 Jan 83</b>                                                      |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD YUKNA</b>                                                                                                                                                                                                                                                                                  |                                                                        | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD. 21231</b> |                                                                                                                            |

|                                                                                           |                             |                                                                  |                                                                        |
|-------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------|------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(BURIAL)                                               | 23b. DATE<br><b>1/20/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. c. March F/H Inc. 1101 E. North Avenue</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1983</b>              | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Lander</i>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DAVIS, LEWIS C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate for the deceased must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 2 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                               |                                                                                                                                                             |  |                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEWIS C DAVIS                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 2 83 |                                                                                                                                                             |  | 2b. HOUR<br>2:55 PM                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>WHITE                                                                                                                   |                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 10 11                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |                                                        |  |                                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD                                |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNW. OF MARYLAND HOSP |                                               |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MarineShop                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |                                               | 13b. COUNTY<br>LINCOLN                                                                                                                                      |  | 13c. CITY OR TOWN                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  |                                                                                                                            |  | 13e. STREET ADDRESS<br>303 NANCY AVE 21090             |  |                                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM C. DAVIS                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE E. SWEENEY                                                                                           |  |                                                                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                |  |                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>217-14-6962                |  | 17. INFORMANT<br>ADDRESS<br>Rena C. Davis, 303 Nancy Ave., N. Linthicum, Md. 21090 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC COLON CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                    |                                               |                                                                                                                                                             |  |                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |  |                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                            |  |                                                                                                                                    |                                               |                                                                                                                                                             |  |                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                        |  |                                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  |                                                                                                                                    |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from Dec 19 82, to Jan 19 83, that (1) (we) last saw the deceased here on Jan 2 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.                                                          |  |                                                                                                                                    |                                               |                                                                                                                                                             |  |                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 22b. SIGNATURE<br>So no                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                               | DEGREE                                                                                                                                                      |  |                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/2/83                                                                                                 |  |                                                        |  |                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>So                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                               | 22e. ADDRESS<br>22 S. GREENE ST. BACON, MD. 21201                                                                                                           |  |                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                               | 23b. DATE<br>1/5/83                                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cem.                          |  |                                                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk., A.A.Co., Md.                                                   |  |                                                        |  |                                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                               |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1983                                    |  | 25b. REGISTRAR'S SIGNATURE<br>Jan J. Gonce                                                                                                 |  |                                                                                                                            |  |                                                        |  |                                                                                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the envelope after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | REG. NO. 83 00828                                                                                                                                        |  |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JESSE Earl DEBRICK</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 83 7:45 AM                                                                                                         |  |                                                                                                                         |                                              |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE Caucasian                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 10 93                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION South BALTIMORE GENERAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Supervisor for PA. R.R.                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE MD                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | 13b. CITY OR TOWN Anne Arundel PATAWOMEN                                                                                                                 |  | 13c. STREET ADDRESS 8420 Park Road, 21122                                                                               |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES DEBRICK                                                                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA KOHR                                                                                                     |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO. 717-07-6203                                                     |  | 17. INFORMANT ADDRESS Mrs. Shirlee Clause Same as # 13                                                                                                   |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5789 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIAE<br>DUE TO, OR AS A CONSEQUENCE OF (c) GASTROINTESTINAL BLEEDING<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                     |  |                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION -                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) -                                                                         |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13 19 83, to 1/15 19 83, that (I) (we) last saw the deceased alive on 1/15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                        |  |                                                                                          |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <i>Herbert Nvarbe</i> DEGREE                                                                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED 1/15/83                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT NVARBE                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | 22e. ADDRESS 3001 S. HANOVER ST. BALTO., MD.                                                                                                             |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE 1/18/1983                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland                                                              |                                              |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md., 21225 237 E. Patapsco Ave.,                                                                                                                                                                                                                                                                                               |  |                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR JAN 19 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE John J. Conish                                                                               |                                              |

BP

✓



Jan 2 1953







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | REG. NO. 83 00830                                                                                                                                                 |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Verna G DeShong</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 01 18 83                                                                                                                         |  |                                                                                                                            |  |
| 3. SEX <i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE <i>White</i>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>February 18, 1908</i>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY) 64<br>YRS. MONTHS DAYS HOURS MIN.                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington D.C.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Chemist</i>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>                                                                        |  |
| 13a. STATE <i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 13b. COUNTY <i>Baltimore</i>                                                                                                                                      |  | 13c. CITY OR TOWN <i>Baltimore</i>                                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>? Evans</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>Florence ?</i>                                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Yes</i>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO. <i>WW 11 121-10-5776</i>                                                                                        |  | 17. INFORMANT ADDRESS<br><i>Mr Raymond F DeShong Same</i>                                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>severe COPD</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |                                                                                                                                          |  |                                                                                                                                                                   |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                    |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                                   |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Robert Schreiber</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  | DEGREE<br><i>MD</i><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1/19/83</i>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Schreiber</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | 22e. ADDRESS<br><i>Baltimore City Hospitals, Balto, Md 21204</i>                                                                                                  |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><i>1/22/83</i>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i> ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 21 1983</i>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                                                        |  |

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Handwritten text: 1000 18 1141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | REG. NO. 83 00831                                                                                                                             |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WESLEY J. DEW SR.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 25 83                                      |  | 2b. HOUR<br>12:30 PM                                                                                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>WHITE                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 25 08                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                            |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POLICEMAN (SGT.) |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CO.                                                                            |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                                                             |  | 13b. COUNTY<br>BALTIMORE                                                             |  | 13c. CITY OR TOWN<br>BALTO. HGLDS.                                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WESLEY J. DEW                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY TURNER                         |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>NO                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO<br>215-05-2072                                                                                                        |  | 17. INFORMANT ADDRESS<br>AMELIA S. DEW 2918 PENNSYLVANIA AVENUE                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Basal Cell Carcinoma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> , 19 <u>83</u> , to <u>5/25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                            |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>J. L. Soler</u>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br><u>5/25/83</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. L. Soler</u>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |  | 22e. ADDRESS<br><u>30015 HANOVER ST., BALT., MD</u>                                                                                                         |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>01-29-83                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PK.                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MARYLAND              |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. L. Soler</u>                                     |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 8 3 0 0 8 3 2                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| REG. NO.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY C LAST DeWane                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 16 83                                                  |  | 2b. HOUR<br>5 <sup>50</sup> P M                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>white                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 8 05                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bur. of Standards           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov'T                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Montgomery                                                                                                        |  | 13c. CITY OR TOWN<br>CHRY CHASE                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>zip 20815<br>3744 STEWART DR.                                                                       |  |
| 14. FATHER'S NAME<br>FIRST William H. MIDDLE LAST CHILDRESS                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST CARRIE MIDDLE LAST HOUGHTON                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-58-7453                                                           |  | 17. INFORMANT<br>ADDRESS<br>Harold J. DeWane (husband) see #13                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2252 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>12/15/82                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Intraventricular meningioma                                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-7</u> , 19 <u>82</u> , to <u>1-16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                              |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Louis Solomon</u>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br>1/16/83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LOUIS SOLOMON MD                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 22e. ADDRESS<br>University of Maryland Hospital<br>Baltimore, MD                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>Jan. 20, 1983                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Remington Cemetery                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Remington, Virginia                               |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey<br>ADDRESS Bethesda, Maryland                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                |  |                                                                                                                            |  |

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Robert A. Thompson, General Jones, Remington,



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 3 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             |                                                                            |                                                                                                 |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James M. Dial                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 20 1983                        |                                                                                                 | 2b. HOUR<br>5:30 PM                                                                                                        |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>INDIAN                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 10 1934                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.                                 |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Bethesda, MD                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The John Hopkins Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERGY |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>PASTOR                                                                                |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>BALTO                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>25 N. MILTON AVE                                                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROY DIAL SR.                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAGGIE LOCKLEAR                                                                                            |                                                                            |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>246-48-8990                                                                                                                     |                                                                            | 17. INFORMANT<br>WILMA DIAL<br>ADDRESS<br>25 N. MILTON AVE                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CORONARY ARTERY DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) TOBACCO ABUSE |                                                                                                                                        |                                                                                                                                                             |                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                             |                                                                            |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19 1983, to 1/20 1983, that (I) (we) lost saw the deceased alive on 1/20 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                                                                                 |                                                                                                                                        |                                                                                                                                                             |                                                                            |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>Kenneth L. Bandman                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        | DEGREE                                                                                                                                                      |                                                                            | 22c. DATE SIGNED<br>1/20/83                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                        | 22e. ADDRESS                                                                                                                                                |                                                                            |                                                                                                 |                                                                                                                            |
| Kenneth L. Bandman                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | 600 N. WOLFE                                                                                                                                                |                                                                            |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                   | 23b. DATE<br>1-25-83                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>MTELEM CEM                                                                                                            |                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RED SPRING MD CARROLL                             |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>TODD M. WEBER & SONS                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        | ADDRESS<br>401 G CHESTER                                                                                                                                    |                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1983                                                    |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             |                                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                    |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                                                               |                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA MELLOTT DIETRICH                                                                                                                                                                                                                                                                                     |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 29, 1983                                                                                                     |                                                                                                                               | 2b. HOUR<br>7.30p <sub>M</sub>                                |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                  | 4 RACE<br>White                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 12, 1928                                                                                                         |                                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54<br>YRS.                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD. |
| CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH CITY, GIVE STREET ADDRESS)<br>Wyman Park Health System, Inc. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland                                                                                                                                                                                                                           |                                                                                                                                         | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Telmyer                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>May A. Smith                                                                                               |                                                                                                                               |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>--                                                                                                                                                                                                                                                                       |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 22 3907                                                                                      | 17. INFORMANT<br>ADDRESS<br>Charles D. Mellott, Balto., MD                                                                    |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY.<br>5715 } DUE TO, OR AS A CONSEQUENCE OF, ACUTE RENAL FAILURE. + GIBBLEED<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF, CIRRHOSIS OF THE LIVER/ <del>HEPATIC ENCEPHALOPATHY</del><br>(c) } |                                                                                                                                         |                                                                                                                                                             |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                                                               |                                                               |
| 19a. DATE OF OPERATION<br>--                                                                                                                                                                                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>----                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>-----                                                                     |                                                                                                                               |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/>                                                                                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>-----                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>-----                                                                                                  |                                                                                                                               |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from January 03, 1983, to January 29, 1983, that (I) (we) last saw the deceased alive on January 29, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |                                                                                                                                         |                                                                                                                                                             |                                                                                                                               |                                                               |
| 22b. SIGNATURE<br><i>Mirtha Luz Balcazar</i>                                                                                                                                                                                                                                                                                                     |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        | 22c. DATE SIGNED<br>January 29, 83.                                                                                           |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mirtha Luz Balcazar, M.D.                                                                                                                                                                                                                                                                               |                                                                                                                                         | 22e. ADDRESS<br>Wyman Park Health System, Inc., Baltimore, Md.                                                                                              |                                                                                                                               |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                        | 23b. DATE<br>2/1/83                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount                                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD                                                                      |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212                                                                                                                                                                                                                                                   |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983                                                                                                                |                                                                                                                               |                                                               |
|                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                                                                                         |                                                                                                                               |                                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1983 JAN 31

1983 JAN 31

Final Check

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  |                                                                                                                                                          | 8 3 0 0 8 3 5<br>REG. NO.                                                         |                                                                 |                                                                                                                         |                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) AKA FIRST GUSSIE MIDDLE KIRKWOOD LAST DITCH                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR 01 27 83                                         |                                                                 |                                                                                                                         |                                           |
| 3. SEX FEMALE                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                          | 2b. HOUR 2:30 P.M.                                                                |                                                                 |                                                                                                                         |                                           |
| 4. RACE WHITE                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR 07 20 1890                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.                                                                                                                  |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS                                     |                                                                                                                         | IF UNDER 24 HRS. HOURS MIN.               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.         |                                                                                                                         |                                           |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CATON MANOR NURSING CENTER |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINE WORKER                                                                                |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE                  |                                                                                                                         |                                           |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN ARBUTUS                                                                                                         |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                                                   | 13d. STREET ADDRESS 2214 SULPHUR SPRING ROAD, 21227             |                                                                                                                         |                                           |
| 14. FATHER'S NAME FIRST MIDDLE LAST ADAM KIRKWOOD                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET SLOGENHOFF                                                                                           |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. 196-18-3371                                                                                              |  | 17. INFORMANT ADDRESS HELEN I. DITCH 2214 SULPHUR SPRING ROAD 21227                                                                                      |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD with associated<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) cardiac dysrhythmia<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                   |  |                                                                                                                                                          |                                                                                   |                                                                 |                                                                                                                         |                                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  |                                                                                                                                                          |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27/83 to 1/27/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                             |  |                                                                                                                                   |  | 22b. DATE SIGNED 1/31/83                                                                                                                                 |                                                                                   |                                                                 |                                                                                                                         |                                           |
| 22c. SIGNATURE OF PHYSICIAN HERBERT J. LEVICKAS, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 22d. ADDRESS 5404 EAST DRIVE; ARBUTUS, MARYLAND 21227                                                                                                    |                                                                                   | 22e. DATE REC'D. BY REGISTRAR 1/31/83                           |                                                                                                                         |                                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE 01-31-83                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK                                                                                                           |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND |                                                                                                                         |                                           |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 24b. ADDRESS 4107 WILKENS AVE.                                                                                                                           |                                                                                   | 24c. DATE REC'D. BY REGISTRAR 1/31/83                           |                                                                                                                         | 24d. REGISTRAR'S SIGNATURE John J. Conner |

855



*Handwritten notes:*  
To be done  
12/1/22  
12/1/22

*Vertical stamp:* CHALK-DAM

*Vertical stamp:* 100% COTTON



83/183

CHALK-DAM

CHALK-DAM

CHALK-DAM

RELEASED NON-MED DR SMITH PER MR. FREEMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 236, 23c, Film#G577 -

1- FOR STATE REGISTRAR 3/28/83 jlb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 3 6

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               |                                                                                                                                                             |                                                                                              |                                                                                       |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Sumter DIXON</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 17, 1983</b>                               |                                                                                       | 2b. HOUR<br><b>10:59 AM</b>                                                                                                |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>Negro</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 1 1923</b>                                                                                                       |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>59</b>           |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                |                                                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                             |                                               |                                                                                                                                                             | 13b. COUNTY                                                                                  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sumter DIXON SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH</b>                                |                                                                                       |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | 16b. SOCIAL SECURITY NO.<br><b>251-24-7278</b>                                                                                                              |                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Willie Dixon 2821 E. Federal St.</b>                   |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR arrest</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>probable pulmonary embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Hypertension</b> |                                               |                                                                                                                                                             |                                                                                              |                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| 19a. DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                                                                                              |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                      |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 19</b>                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b> |                                                                                       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |                                               | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)<br><b>N/A</b>                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                              |                                                                                       |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 17, 1983</b> to <b>JAN. 17, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                            |                                               |                                                                                                                                                             |                                                                                              |                                                                                       |                                                                                                                            |
| 22b. SIGNATURE<br><b>C. Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                               | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                              | 22c. DATE SIGNED                                                                      |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                               | 22e. ADDRESS<br><b>Dept. of H.M. / JH14</b>                                                                                                                 |                                                                                              |                                                                                       |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                        | 23b. DATE<br><b>1/23/83</b>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Rock</b>                                                                                                     |                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chester S.C.</b>                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>King Funeral 135 Cemetery St. S.C.</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                               | ADDRESS<br><b>Chester S.C.</b>                                                                                                                              |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |

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Handwritten text at the bottom left, possibly a signature or date.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles W. Dockins                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                  |                                            | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 15 19 83                                                       |  |                                                                                                 |  | 2b. HOUR<br>12:54 P M                                |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 30 10                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 |  | 2c. DATE PRONOUNCED DEAD<br>1 16 19 83                                                          |  | 2d. HOUR<br>P M                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>401 E. 25th Street |                                            |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 13b. COUNTY                                                                                                                      |                                            | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>401 E. 25th St. Apt. 4P 21218 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Dockins                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                  |                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Adams                                                                                              |  |                                                                                                 |  |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                            |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-5603                                                           |                                            | 17. INFORMANT ADDRESS<br>Ellicott City, Md.<br>Frances Wilson 9884 Foxhill Ct. 21043                                                                        |  |                                                                                                 |  |                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                        |                  |                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |                                            |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                                                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10                                                                       |                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                      |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                      |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith                                                                                                                                                                                                                                                                                                                                                                                                    |                  | TITLE (SPECIFY)<br>Deputy Chief                                                                                                  |                                            |                                                                                                                                                             |  | MEDICAL EXAMINER                                                                                |  | DATE SIGNED<br>1/17/83                               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                            |                  | ADDRESS<br>111 Penn St. Balto., MD.                                                                                              |                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                              |                  | 23b. DATE<br>1/21/83                                                                                                             |                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.                                       |  |                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                  |                                            | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                    |  |                                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |  |                                                                                                                          |  | REG. NO. 83 00838                                                                                                                                        |  |                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 1-20-83                                                                                                                 |  |                                                                               |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN D. DOGGETT                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                          |  | 2b. HOUR 9:30 P.M.                                                                                                                                       |  |                                                                               |  |
| 3. SEX MALE                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE White                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR 2 12 93                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.                       |  |
| 10. CITY OR TOWN OF DEATH CITY - BALT                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAPTAIN                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY HARBOR FIRE DEPT.                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                          |  |                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                               |  |
| 13a. STATE MD                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY BALT                                                                                                         |  | 13c. CITY OR TOWN BALT                                                                                                                                   |  | 13e. STREET ADDRESS 4505 Eastway 21212                                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID DOGGETT                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE MOORE                                                                                                  |  |                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                          |  | 16b. SOCIAL SECURITY NO. 217-38-2465                                                                                                                     |  | 17. INFORMANT John B. Doggett ADDRESS 4505 Eastway Baltimore Md.              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4860 Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  |                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-20-83 to 1-20-83, that (I) (we) lost the deceased alive on 1-20-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                               |  |
| 22b. SIGNATURE [Signature]                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                          |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED 1-21-83                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. S. NAIR, M.D.                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  | 22e. ADDRESS 5010 York Rd, BALT - MD 21222                                                                                                               |  |                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE 1-26-83                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY BETHEL CHURCH CEM. - LIVERY LANCASTER VA                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY                                             |  |
| 24. FUNERAL DIRECTOR [Signature]                                                                                                                                                                                                                                                                                                                                                                 |  | MITCHELL - WIEDEFELD F. H. 6500 YORK RD BALT, Md.                                                                        |  | 25a. DATE REC'D BY REGISTRAR FEB 1 1983                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE [Signature]                                        |  |



JOHN D. DECEIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for 24 hours after death. Please retain the certificate for 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                       |  |  |  | 8 3 0 0 8 3 9                                                                                                                                                                    |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                     |  |  |  | REG. NO.                                                                                                                                                                         |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Royce</i>                                                                                                                                                                                                                                                                                                                           |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-23-83</i>                                                                                                                                  |  |  |  |
| 3. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 2b. HOUR <i>2:15</i> M                                                                                                                                                           |  |  |  |
| 4. RACE <i>W</i>                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i>                                                                                                                                        |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>                                                                                                                                                                                                                                                                                                                 |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>                                                                                                                                         |  |  |  |
| 7c. DATE OF BIRTH MONTH DAY YEAR <i>8-01-17</i>                                                                                                                                                                                                                                                                                                                            |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                         |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>                                                                                                                                                                                                                                                                                                                 |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cab driver</i>                                                                                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                 |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp.</i>                                                                                                                                                                                                                                               |  |  |  | 13a. STATE <i>MD.</i>                                                                                                                                                            |  |  |  |
| 13b. COUNTY                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 13c. CITY OR TOWN <i>Baltimore</i>                                                                                                                                               |  |  |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  |  |  | 13e. STREET ADDRESS <i>102 N. Poca Street</i>                                                                                                                                    |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Donohue</i>                                                                                                                                                                                                                                                                                                                 |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Verna Ninneman</i>                                                                                                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>                                                                                                                                                                                                                                                                                                |  |  |  | 16b. SOCIAL SECURITY NO. <i>337019596</i>                                                                                                                                        |  |  |  |
| 16c. INFORMANT ADDRESS <i>VERA McDONALD 9014 Rode Island</i>                                                                                                                                                                                                                                                                                                               |  |  |  | 17. INFORMANT ADDRESS                                                                                                                                                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i><br>4379<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebrovascular disorders</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Schizophrenia, COPD, seizure disorder</i> |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                 |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19 83</i>                                                                                                                        |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                                                                                                                                                                                                                                             |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                           |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                        |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 20</i> 19 <i>83</i> , to <i>Jan 23</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Jan 23</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  | 22b. SIGNATURE <i>John M. Bathon MD</i> DEGREE <i>MD</i>                                                                                                                         |  |  |  |
| 22c. DATE SIGNED <i>1/23/83</i>                                                                                                                                                                                                                                                                                                                                            |  |  |  | 22d. PHYSICIAN'S NAME (TYPE CURRENT) <i>J. Bathon</i>                                                                                                                            |  |  |  |
| 22e. ADDRESS <i>Lutheran Hospital</i>                                                                                                                                                                                                                                                                                                                                      |  |  |  | 22f. ADDRESS                                                                                                                                                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>                                                                                                                                                                                                                                                                                                                   |  |  |  | 23b. DATE <i>1/26/83</i>                                                                                                                                                         |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                                         |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                          |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>                                                                                                                                                                                                                                                                                                                             |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 28 1983</i>                                                                                                                                 |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>                                                                                                                                                                                                                                                                                                                            |  |  |  | 25c. REGISTRAR'S SIGNATURE                                                                                                                                                       |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the vital records office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

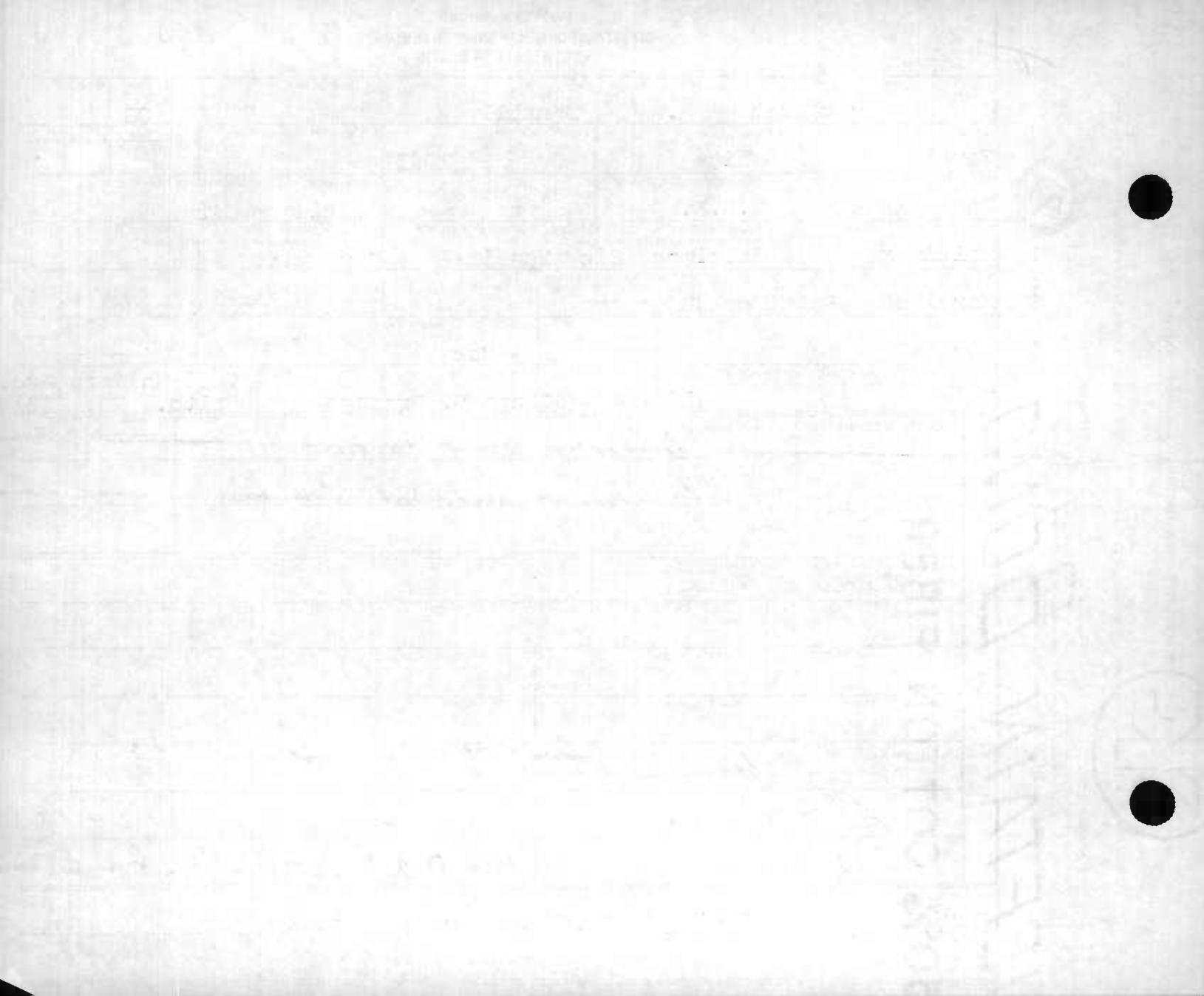
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         |                                                                                                                                                            |                                                                                  | 8 3 0 0 8 4 0                                                                 |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                            |                                                                                  | REG. NO.                                                                      |                                              |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret A. Donnelly</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br><b>1 22 83</b>                                |                                                                               | 2b HOUR<br><b>M</b>                          |
| 1. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br><b>White</b>                                                                                                                  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 22 1895</b>                                                                                                        |                                                                                  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS                               |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                     | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD               |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                        | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |                                                                                                                                                            | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY             |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         |                                                                                                                                                            | 13b COUNTY<br><b>Baltimore</b>                                                   | 13c CITY OR TOWN<br><b>Edgemere</b>                                           |                                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael Curran</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                         |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Tierney</b>                 |                                                                               |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                         |                                                                                                                                                            | 16b SOCIAL SECURITY NO.<br><b>149-20-4356</b>                                    |                                                                               |                                              |
| 17 INFORMANT ADDRESS<br><b>Anna D. Dravage</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         |                                                                                                                                                            | 7208 Waldman Avenue 21219 Balto., MD. 21219                                      |                                                                               |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive Ant. Sol. C.V. Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                         |                                                                                                                                                            |                                                                                  |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Osseo an Phit</b>                                                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                            |                                                                                  |                                                                               |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |                                                                                                                                         | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                                  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Jan 1971</b> 19 <b>83</b> , to <b>Jan 21</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Dec 10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |                                                                                                                                         |                                                                                                                                                            |                                                                                  |                                                                               |                                              |
| 22b SIGNATURE<br><b>R G Windsor</b>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | DEGREE                                                                                                                                                     |                                                                                  | 22c DATE SIGNED<br><b>1-24-83</b>                                             |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R G WINDSOR</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 22e ADDRESS<br><b>1012 Old North Point Rd. 21222</b>                                                                                                       |                                                                                  |                                                                               |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 23b DATE<br><b>1/27/1983</b>                                                                                                                               |                                                                                  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cem.</b>                   |                                              |
| 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Wilkes-Barre Pa.</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 24 FUNERAL DIRECTOR Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222                                                                                    |                                                                                  |                                                                               |                                              |
| 25a DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 25b REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                                                                                          |                                                                                  |                                                                               |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                           |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | REG. NO. |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILSON J. DORSEY                                                                                                                                                                                                                                                   |  |                                                                                                                             |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 4 1983                                                 |  | 2b. HOUR<br>11:10pm                                                                                                        |  |          |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>BLACK                                                                                                            |  | 5. DATE OF BIRTH<br>10 <sup>TH</sup> 12 <sup>Y</sup> 1895                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                                                                                                            |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Balt                                                                                                         |  | 13c. CITY OR TOWN<br>Catonsville                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>129 Winters Lane 21228                                                                              |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wesley Dorsey                                                                                                                                                                                                                                                                        |  |                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Moore                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                         |  |                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                                                             |  | 17. INFORMANT<br>ADDRESS<br>James W. Wade 129 Winters Lane                                      |  |                                                                                                                            |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a). CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b). ASCVD COMPLETE CONDUCTION BLOCK.<br>DUE TO, OR AS A CONSEQUENCE OF (c).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>HEMORRHOIDS                                                                                                                                                                                |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 19a. DATE OF OPERATION<br>N/A                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 1982, to JAN 1983, that (I) (we) lost<br>saw the deceased alive on 12/31/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) (sign) this body after death.          |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 22b. SIGNATURE<br>FABIO K. BANEGUERA, MD                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |                                                                                                 |  | 22c. DATE SIGNED<br>01/08/83                                                                                               |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FABIO K. BANEGUERA, MD                                                                                                                                                                                                                                                                |  |                                                                                                                             |  | 22e. ADDRESS<br>1532 Havenwood Rd BALTO, MD 21218 Phone: 366-1188                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>1/8/83                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland                           |  |                                                                                                                            |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Avenue ADDRESS                                                                                                                                                                                                                                                  |  |                                                                                                                             |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>J. L. G. G. G.                                                                               |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO.                                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MOLLIGE H DOTY                                                                                                                                                                                                                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-31-1983                                                                                  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                           |  | 2b. HOUR<br>10:50 <sup>A</sup> <sub>M</sub>                                                                                    |  |
| 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR<br>78 YRS.                                                                      |  |
| 5. DATE OF BIRTH<br>6/23/04                                                                                                                                                                                                                                                                                                                                                                                |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA.                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Belair Convalesarium |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSEW                                                                                                                                                                                                                                                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br>MD. BALTO                                                                                                                                                                                                                                                                                     |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 13c. CITY OR TOWN<br>ESSEX                                                                                                                                                                                                                                                                                                                                                                                 |  | 13d. STREET ADDRESS<br>21221 364 NICHOLSON RD.                                                                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ALFRED GINS                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MOLLIGE VOLLAND                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>DNR                                                                                                |  |
| 17. INFORMANT ADDRESS<br>VALERIA BAYMER ABOVE                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Acute Circulatory Collapse<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Stroke, Cachexia, Contractures, Diabetes mellitus, Recurrent uric acid infarct.                                                                                                                                                                                  |  |                                                                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                                                             |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                 |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                 |  |
| 22a. I certify that (I) (we) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                               |  | 22b. SIGNATURE<br>Albert B. Bradley                                                                                            |  |
| 22c. DATE SIGNED<br>1/31/83                                                                                                                                                                                                                                                                                                                                                                                |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT B. BRADLEY, M.D.                                                               |  |
| 22e. ADDRESS<br>4900 Belair Rd. Balto., Md. 21206                                                                                                                                                                                                                                                                                                                                                          |  | 22f. ADDRESS                                                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>2/3/83                                                                                                            |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>MORELANDS                                                                                                                                                                                                                                                                                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD                                                                           |  |
| 24. FUNERAL DIRECTOR NAME<br>J.B. CONNELLY                                                                                                                                                                                                                                                                                                                                                                 |  | 24b. ADDRESS<br>300 MACE                                                                                                       |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1983                                                                                                                                                                                                                                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Sam J. Connelly                                                                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   | 8 3 0 0 8 4 3                                           |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   | REG. NO.                                                |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN THOMAS DOUGHERTY                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 15 83                     |                                                                                                                            |                                   | 2b. HOUR<br>2:27A M                                     |  |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 20 1913                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                                                      |                                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                   | IF UNDER 24 HRS<br>HOURS MIN.                           |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, Baltimore, Maryland 21218 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Air Force              |                                                                    |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                         |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                                  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                    | 13e. STREET ADDRESS<br>616 South Eaton St. 21224                                                                           |                                   |                                                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Dougherty                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Rodgers                                                                                              |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1939-1950                                                                         |  | 17. INFORMANT<br>Iva L. Dougherty                                                                                                                           |  | ADDRESS<br>616 S. Eaton St.<br>Balto., MD. 21224                                                |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5188 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) END STAGE LUNG DIS. Years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3-5 yrs |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Smoking Habit of Pt.                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 19a. DATE OF OPERATION<br>2/18/83                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>4A                                                                                       |  |                                                                                                                                                             |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>4A                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 22a. I certify that XX (this hospital) attended the deceased from January 12, 1983, to January 15, 1983, that I (we) last saw the deceased alive on January 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) (did not) view the body after death.             |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 22b. SIGNATURE<br>C. GEAN                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |                                                                    | 22c. DATE SIGNED<br>1-15-83                                                                                                |                                   |                                                         |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. GEAN                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 22e. ADDRESS<br>VAMC, Baltimore, Maryland 21218                                                                                                             |  |                                                                                                 |                                                                    |                                                                                                                            |                                   |                                                         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>1/18/1983                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville                                                                                                           |  |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Maryland |                                                                                                                            |                                   |                                                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, MD. 21222                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                                    |                                                                    | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                               |                                   |                                                         |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  | 8 3 0 0 8 4 4                                                                                                                                               |  |                                                                                                                         |                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                                                                             |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM WENDELL DOUGHTY</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 5 83</b>                                                                                                           |  | 2b. HOUR MIN<br><b>12:40<sup>a</sup></b>                                                                                |                                                                                             |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9/28/1931</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>51</b>                                                                       |                                                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                                            |                                                                                             |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                                                                             |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                    |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13d. STREET ADDRESS<br><b>917 Bennett Place</b> <b>21223</b>                                                            |                                                                                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Eddie Anderson</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louise Doughty</b>                                                                                         |  |                                                                                                                         |                                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>216 28 6164</b>                                                                                                  |  | 17. INFORMANT ADDRESS<br><b>Dinah Bethea 3215 Mondawmin Ave.</b>                                                                                            |  |                                                                                                                         |                                                                                             |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>2738</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>anoxia</b><br>(c) <b>hypoxemia</b>                   |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>months</b><br><b>yes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                   |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |                                                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                         |                                                                                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                                                                             |
| 22a. I certify that (this hospital) attended the deceased from <b>December 29, 19 82</b> , to <b>January 5, 19 83</b> , that (we) last saw the deceased alive on <b>January 5, 19 83</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (not) view the body after death. |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                         |                                                                                             |
| 22b. SIGNATURE<br><b>Ronan B. Wills MD</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>1/6/83</b>                                                                                       |                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronan B. Wills MD</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 22e. ADDRESS<br><b>L</b>                                                                                                                                    |  |                                                                                                                         |                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>1/10/83</b>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cem.</b>                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b>                                                       |                                                                                             |
| 24. FUNERAL DIRECTOR NAME<br><b>Chas. A. Rice FSPA</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | ADDRESS<br><b>1300 Eutaw Place</b>                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>                                                                     |                                                                                             |
|                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                         |  |                                                                                                                         |                                                                                             |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  | 8                                                                                                                          | 3 | 0                             | 0 | 8                                        | 4 | 5 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|---|-------------------------------|---|------------------------------------------|---|---|
| 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  | REG. NO.                                                                                                                   |   |                               |   |                                          |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>R. J. B. Douglas</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 11 83</i>                                                                      |   |                               |   | 2b. HOUR<br><i>140A</i>                  |   |   |
| 3. SEX<br><i>M</i>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><i>B</i>                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>07 11 10</i>                                                                                                       |  |                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |   | IF UNDER 24 HRS<br>HOURS MIN. |   |                                          |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>md.</i>                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.             |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ of Md</i> |  |                                                                                                                                                             |  |                                                                               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |   |                               |   |                                          |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   |                               |   | 13e. STREET ADDRESS<br><i>PO BOX 172</i> |   |   |
| 13a. STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><i>Queen Annes</i>                                                                                              |  | 13c. CITY OR TOWN<br><i>Church Hill</i>                                                                                                                     |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Bonifant Douglas</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Annie Forman</i>                                                                                        |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT<br><i>Jarvis E Douglas</i>                                      |  |                                                                                                                                            |  | ADDRESS<br><i>Douglas</i>                                                                                                  |   |                               |   |                                          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i><br><i>1369</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Septicemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Unidentified focus of infection</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |   |                               |   |                                          |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 19a. DATE OF OPERATION<br><i>Numerous</i>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>—</i>                                                                                                |  |                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                               |   |                                          |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/22</i> , 19 <i>82</i> , to <i>1/11</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/11</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                      |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 22b. SIGNATURE<br><i>Kenneth Rock</i>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  |                                                                                                                                                             |  | DEGREE<br><i>MD</i>                                                           |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1/11/82</i>                                                                                         |   |                               |   |                                          |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kenneth Rock</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  |                                                                                                                                                             |  | 22e. ADDRESS<br><i>22 S GREEN ST BALT Md.</i>                                 |  |                                                                                                                                            |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 23b. DATE<br><i>1/14/82</i>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Church hill</i>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Church 9th Md</i>                                                                         |  |                                                                                                                            |   |                               |   |                                          |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Sam A Roslund Esq Md</i>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 17 1983</i>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>                                                                                        |  |                                                                                                                            |   |                               |   |                                          |   |   |

BP



20% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 8 3 0 0 8 4 6                                                                                                                                               |  |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Clayborne J. Dowell</b><br><i>(C. Claybourne) Dowell</i>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 8 83</b>                                                                                                           |  | 2b. HOUR <b>3</b> P.M.                                                                                                  |                                              |
| 3 SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE <b>Black</b>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 6 03</b>                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Providence Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  | 13b. COUNTY <b>Baltimore</b>                                                                                                                                |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                      |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Dowell</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sallie Dowell</b>                                                                                             |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>212-14-2349</b>                                                                                       |  | 17. INFORMANT ADDRESS <b>Ruby Rogers 3012 Auchentoroly Terrace</b>                                                                                          |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest, Pulmonary</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive Cerebral Infarct</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-8-83</b> 19 <b>83</b> , to <b>1-8-83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                     |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>M. Wellman</b> MD                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  | DEGREE <b>MD</b>                                                                                                                                            |  | 22c. DATE SIGNED <b>1-8-83</b>                                                                                          |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mania Wellman</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  | 22e. ADDRESS <b>2600 Liberty Hgts</b>                                                                                                                       |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <b>1/14/83</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat'l Mem. Pk.</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel MD</b>                                                                |                                              |
| 24. FUNERAL DIRECTOR NAME <b>Wm. March F.H.</b> ADDRESS <b>1101 E. North Ave</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 25a. DATE RECEIVED BY REGISTRAR <b>JAN 10 1983</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                                                                        |                                              |

MEMORANDUM FOR THE SECRETARY OF AGRICULTURE  
SUBJECT: [Illegible]

TO: [Illegible]

FROM: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00847

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                             |                                               |                                                                                                                                                             |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE ALBERT DRURY                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/3/83 |                                                                                                                                                             | 2b. HOUR<br>8:45 P.M. |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                            |                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 22, 1903                                                                                                         |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                               |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                              |  |                                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |                                               |                                                                                                                                                             |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Highway Maintenance |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto.                                                     |  |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Virginia                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                               |                                                                                                                                                             |                       | 13b. CITY OR TOWN<br>Sutherland                                                         |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>Rt. 1, Box 117                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Drury                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Russell                                                                                               |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                               | 16b. SOCIAL SECURITY NO.<br>217 07 0464                                                                                                                     |                       | 17. INFORMANT<br>ADDRESS<br>J. T. Morriss & Son, Inc., VA                               |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>3109 IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>organic Brain Syndrome.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 Days |  |                                                                                                                             |                                               |                                                                                                                                                             |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Seizure Disorder</u>                                                                                                                                                                                                                                                                                              |  |                                                                                                                             |                                               |                                                                                                                                                             |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                       |                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                             |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from <u>12/27</u> , 19 <u>82</u> , to <u>1/3</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>1/3</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                   |  |                                                                                                                             |                                               |                                                                                                                                                             |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>M. Cansell MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                       |                                                                                         |  | 22c. DATE SIGNED<br>1/3/83                                                                      |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. GARROU</u>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                               | 22e. ADDRESS<br><u>301 ST. PAUL ST. BALTO. MD.</u>                                                                                                          |                       |                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal-Burial                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                             |                                               | 23b. DATE<br>1-4-83                                                                                                                                         |                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Southlawn Cemetery                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Prince George, VA                                 |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |                                               | ADDRESS<br>4905 York Rd.                                                                                                                                    |                       | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983                                             |  | 25b. REGISTRAR'S SIGNATURE<br><u>Joan J. Cansell</u>                                            |  |                                                                                                                            |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 4 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                         |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                             |                                                                 |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN T DUBBS                |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 31 1983<br>2b. HOUR<br>7:30 PM                        |                                                             |                                                                 |
| 3. SEX<br>Male                                                                          | 4. RACE<br>White                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 28, 1973                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>10<br>YRS.                                                   |                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                     |                                                             |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |                                                             | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                             |                                                                 |
| 13a. STATE<br>Pennsylvania                                                              | 13b. COUNTY                                                                                                                             | 13c. CITY OR TOWN<br>York                                                                                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>79977<br>705 Cedar Village           |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Donald M. Dubbs                               |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joanne M. Horner                                                                                           |                                                                                                 |                                                             |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>None                                                                                                                            |                                                                                                 | 17. INFORMANT<br>Donald M. Dubbs<br>ADDRESS<br>Same as #13. |                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1150

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Pulmonary Histocytosis X

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 day

4 mo.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                                            |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                               |
| 22a. I certify that (1) <del>the hospital</del> attended the deceased from Jan 1983, to Feb 1983, that (1) <del>was</del> lost<br>saw the deceased alive on 1/31 1983, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (1) <del>was</del> <del>did not</del> view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                               |
| 22b. SIGNATURE<br><i>Norman Saba</i>                                                                                                                                                                                                                                                                                                                     | DEGREE                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>1/31/83                                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Norman SABA MD                                                                                                                                                                                                                                                                                                  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                 |                                                                                                                                            |                                                                                                                               |

|                                                                                          |                           |                                                             |                                                                           |
|------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                   | 23b. DATE<br>Feb. 3, 1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>Suburban Mem. Gardens | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dovertownship, Pennsylvania |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204 |                           | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1983                 | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate of a person who dies in a hospital or nursing home be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  | 8 3 0 0 8 4 9                                                                                                                                               |  |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Patricia Dubicki</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |  | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 16, 1983</b>                                                                                              |  | 7b. HOUR<br><b>8:50 AM</b>                                                                                                 |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Cauc.</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/9/42</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS                                                                           |                                              |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                                                                            |  | 12b. KIND OF BUSINESS OR<br><b>Patrilton Nursing Home</b>                                                                  |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                         |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Obrigkeit</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carmela (nee Bonomo)</b>                                                                                |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>215-42-5552</b>                                                                                                |  | 17. INFORMANT<br>ADDRESS<br><b>Raymond Dubicki, 4116 Link Ave. 21236</b>                                                                                    |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>3484</b> IMMEDIATE CAUSE (a) <b>Cerebellar Tonsillar Herniation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Uncinate Herniation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Multiple Myeloma with Multiple Viscera and Boney Involvement</b>                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (this hospital) attended the deceased from <b>December 13, 1982</b> to <b>January 16, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>January 16, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (We) (did) (did not) view the body after death.                                                   |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Richard H. Lane</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>1/16/83</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Lane, M.D.</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>1/19/83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cem.</b>                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |                                              |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>Schimmunek Funeral Home, Inc.<br/>9705 Belair Road, Balto., Md. 21236</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 18 1983 John J. Connel</b>                                                               |  |                                                                                                                            |                                              |



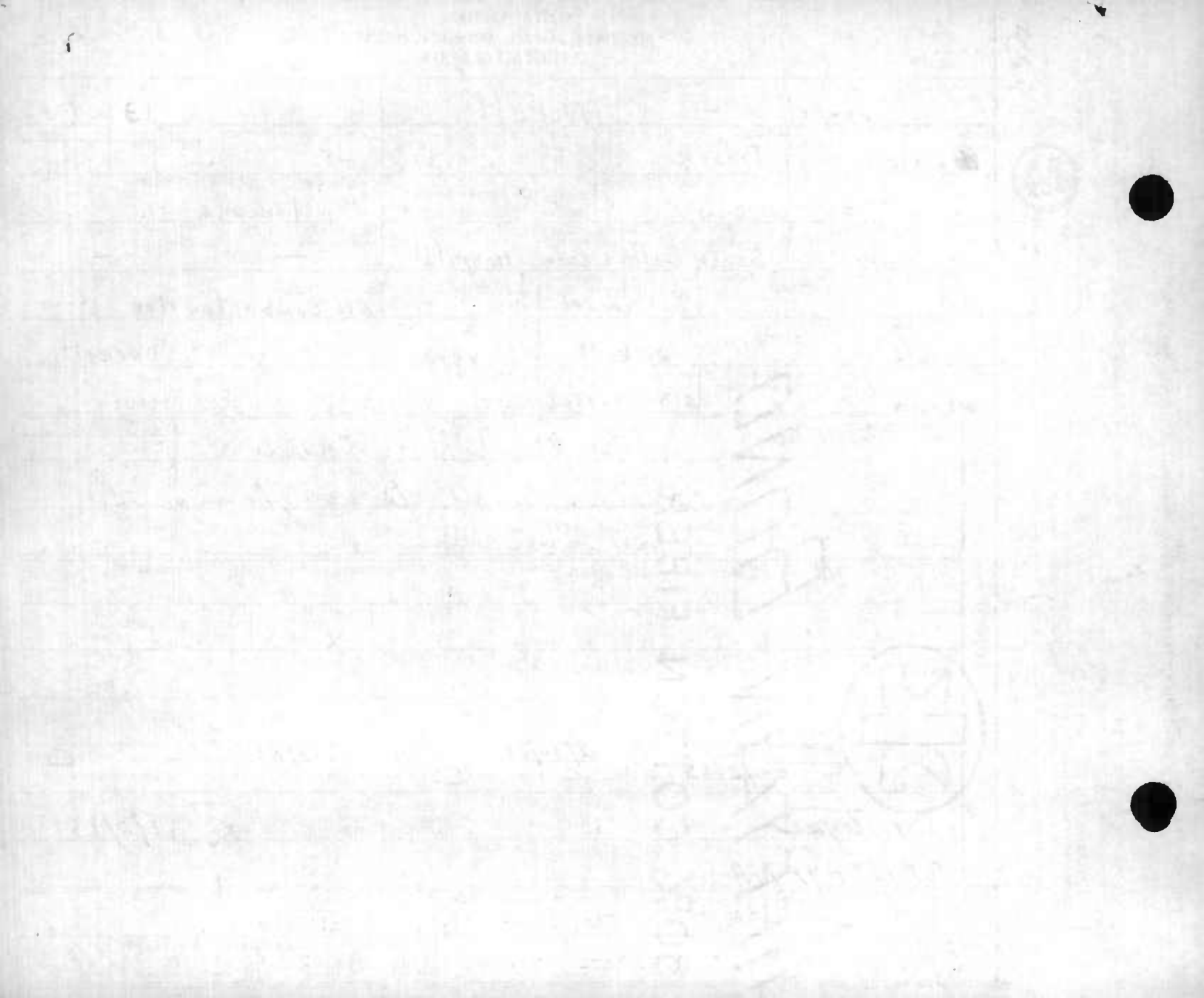
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | REG. NO. 83 00850                                                                                                                                           |  |                                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Lendell - Duckett</u>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 83 2:50 P.M.                                                                                                           |  |                                                                                                                                            |                                              |
| 3. SEX <u>male</u>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <u>Black</u>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 11 37                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) 45                                                                                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>S. Carolina</u>                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.                                                                             |                                              |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Balto. Gen. Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>-</u>                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>-</u>                                                                                                 |                                              |
| 13a. STATE <u>MD.</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 13b. COUNTY <u>Baltimore</u>                                                                                                                                |  | 13c. CITY OR TOWN <u>Baltimore</u>                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>oc. Duckett</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Vera Duckett</u>                                                                                              |  |                                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>unknown</u>                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <u>213-34-6502</u>                                                                                              |  | 17. INFORMANT ADDRESS <u>Gloria Duckett 616 Dunbarton Avenue</u>                                                                                            |  |                                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Ling, terminal</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>with mutations</u>                                                                       |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>1629</u>                                                                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                            |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                            |                                              |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12/30/82</u> , 19____, to <u>1/2/83</u> , 19____, that (I) <u>(we)</u> last saw the deceased alive on <u>1/2/83</u> , 19____, and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |                                              |
| 22b. SIGNATURE <u>Santayana</u> DEGREE                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 22c. DATE SIGNED <u>1/2/83</u>                                                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SANTAYANA</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (STATE) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE <u>1/7/83</u>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>King Memorial pk.</u>                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co. Md.</u>                                                                           |                                              |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. Arch F/h Inc. 1101 E. North Ave.</u>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 6 1983</u> REGISTRAR'S SIGNATURE <u>John J. Connel</u>                                                                 |  |                                                                                                                                            |                                              |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 83 00851                                                                                                                                                 |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR <i>Eean K.</i>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><i>Baby Boy Duffie</i>                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1/11/83</i>                                                                                                       |  | 2b. HOUR<br><i>246 P.M.</i>                                                                                             |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><i>Black</i>                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>1 9 83</i>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><i>1 Day</i> YRS. MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ. of Md. Hosp</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>NA</i>                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>NA</i>                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br><i>MD NA BALTIMORE</i>                                                                                                                                                                            |  |                                                                                                                                    |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13c. STREET ADDRESS<br><i>Mom's 2926 THE Alameda 21218</i>                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Kim Lindell Robinson</i>                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mischa Duffie</i>                                                                                       |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>N/A</i>                                                                                                                                                                                                                 |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><i>N/A</i>                                                                                                                   |  | 17. INFORMANT ADDRESS<br><i>Joseph Duffie 1318 E. Coldspring La.</i>                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>7651 IMMEDIATE CAUSE (a) Cardiopulmonary failure</i>                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i>                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>SEVERE PREMATUREITY 29 WKS 6A.</i>                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                          |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                            |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE DEGREE<br><i>Mary Lenore Keszler MD</i>                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  | 22c. DATE SIGNED<br><i>1-11-83</i>                                                                                                                       |  | 22d. ADDRESS<br><i>22-5 GREENE ST. BALTIMORE MD.</i>                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><i>1/17/83</i>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem</i>                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co., Md.</i>                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm C March F/H</i>                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 17 1983</i>                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>                                                                        |  |
| ADDRESS<br><i>1101 E. North Ave.</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |

BP



100% COTTON

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |                                                                          |                                                                                                                                                             |  |                                                                                                                              |                      |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAURA KATE DUNNEBACK</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/27/83</b>                   |                                                                                                                                                             |  | 2b. HOUR<br><b>5:20p</b>                                                                                                     |                      |                                                                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 28, 1955</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>27</b>                                                                                 |                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                            |                      |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                          |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                                              |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                                      |  |
| 13a. STATE<br><b>Florida</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. CITY OR TOWN<br><b>Indian Harbor Beach</b>                                                                                                |                                                                          | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 13d. STREET ADDRESS<br><b>141 Genoa St. 32937</b>                                                                            |                      |                                                                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Dunneback, SR.</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catharine Branch</b> |                                                                                                                                                             |  |                                                                                                                              |                      |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                                        |                                                                          | 17. INFORMANT<br><b>Marshall Bracey, F.D.,</b>                                                                                                              |  |                                                                                                                              | ADDRESS<br><b>TN</b> |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Mediastinal Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Major vessel Hemorrhage</b> |  |                                                                                                                                                |                                                                          |                                                                                                                                                             |  |                                                                                                                              |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>30 min</b><br><b>30 min</b>                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Dependence on Pressors - (DOBUTAMINE)</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                                          |                                                                                                                                                             |  |                                                                                                                              |                      |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>1/14/83</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Double outlier @ venous</b>                                                             |                                                                          |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                         |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                                              |                      |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br><input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1/14/83 19</b><br><b>1/27 1983</b>                                                                  |  | 22. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. |                      |                                                                                                                                       |  |
| 22a. SIGNATURE<br><b>E. Ruas MD</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE<br><b>MD</b>                                                                                                                            |                                                                          | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/27/83</b>                                                                                           |                      |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUAS</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                                          | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                               |  |                                                                                                                              |                      |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal-Burial</b>                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>1/28/83</b>                                                                                                                    |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Nashville Davidson Co., TN</b>                                              |                      |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., MD 21212</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                          |                      |                                                                                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



RECEIVED

W. A. GORDON, JR., PRESIDENT

First National Bank

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

Jan 31 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

item 23b call w/fh 1/18/83 ph 83 00853

FOR  
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA L. DUNSTON</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 12 83</b>                                           |                                                                                                | 2b. HOUR<br><b>8:25 AM</b>        |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>BLACK</b>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 10 02</b>                                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80 YRS.</b>                                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>80</b>                                                 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD                                   |                                                                                                |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BLANCAFLOR NURSING HOME</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC WORKER</b>      |                                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                 |                                                                                                |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                          |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>215-22-6739</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>HEULITT DUNSTON - 615 GLENWOOD AVE</b>                          |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Carcinoma, lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ASCVD</b>                                                                                                                                                                                                        |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                |                                   |
| 19a. DATE OF OPERATION<br><b>1/11/83</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ASCVD</b>                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>ASCVD</b> |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                              |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/83</b> to <b>1/12/83</b> , that (I) (we) last saw the deceased alive on <b>1/11/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                |                                   |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED                                                                               |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                             |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><b>M.D.</b>                                                                    |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                             | 23b. DATE<br><b>1/15/83</b>                                                                                                                                 |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEMORIAL PK RANDALLSTOWN MD.</b>                 |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>REDD FUNERAL HOME - 5209 YORK RD.</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                             | ADDRESS<br><b>BALTO. MD.</b>                                                                                                                                |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                            |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                |                                   |

BP.



DATE CITY

VII

HEALING DURING - 1952

RECEIVED FROM THE  
BUREAU OF THE  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                          |                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                                             |                                           |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>THEODORE R. DUSZYNSKI</b> |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-20-83</b>                                          |                                                                                                             | 2b. HOUR<br><b>8:03pm</b>                 |
| 3. SEX<br><b>Male</b>                                                                    | 4. RACE<br><b>Cauc.</b>                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 04 1912</b>                                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                                                    |                                                                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County City MD.</b>                        |                                                                                                             |                                           |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                           |                                           |
| 13a. STATE<br><b>Maryland</b>                                                            | 13b. COUNTY<br><b>Baltimore</b>                                                                                                 | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1911 Crofton Ave., 21222</b>                                                      |                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                 |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine ? ?</b>                                                                                       |                                                                                                 |                                                                                                             |                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>       |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>215-10-8321</b>                                                                                                              |                                                                                                 | 17. INFORMANT ADDRESS<br><b>1911 Crofton Avenue</b><br><b>Mrs. Dorothy Duszynski - Baltimore, Md. 21222</b> |                                           |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5560 IMMEDIATE CAUSE (a) **CARDIO RESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**XXII DIABETES MELLITUS**

|                                                                                                                                                                                                                                                                                                                       |                                                                               |                                                                                                                                                      |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>01-08-83</b>                                                                                                                                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ULCERATIVE COLITIS</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                                               |
| 22a. I certify that (I) this hospital attended the deceased from <b>01-09-83</b> to <b>01-20-83</b> , that (I) we lost<br>saw the deceased alive on <b>01-20-83</b> , and that in (my) our opinion death occurred on the date and hour and from the causes stated<br>above, (I) we did not view the body after death. |                                                                               |                                                                                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>K George Thomas</b>                                                                                                                                                                                                                                                                              |                                                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>1/20/83</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. GEORGE THOMAS M.D.</b>                                                                                                                                                                                                                                                |                                                                               | 22e. ADDRESS<br><b>100 n. BROADWAY BALTIMORE, MARYLAND 31</b>                                                                                        |                                                                                                                               |

|                                                                         |                              |                                                          |                                                                     |
|-------------------------------------------------------------------------|------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>           | 23b. DATE<br><b>01/25/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Walter abrowski 1005 Dundalk Ave. #21224</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>      | 25b. REGISTRAR'S SIGNATURE<br><b>John E. G...</b>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.



412

• 2000

IN THE CIRCUIT COURT OF THE FIRST JUDICIAL DISTRICT OF FLORIDA, IN AND FOR THE COUNTY OF ALACHSA

5001 (30)

• 1 • 2 • 3 •

U.S. Forest Service

Productive

Church Home

berlin

## Background

from 11 to 15

1111 CROTON AVE., S1135

1500000

Losses

20

25Y

512-10-251

1111 Crofton Avenue  
Baltimore, Md. 21211

1891

CE/21/10

reason why

• 100 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CLEMENT A. EARLES</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 5 82</b>                              |                                                                                              |                                                                                   |                                                                      |                                                                                                                         | 2b. HOUR<br><b>7:40 PM</b>                   |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>WHITE</b>                                                                                                                        |                                                                                                  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 9 94</b>                                                                                                         |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                            |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS                                          |                                                                                                                         | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                      |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSP.</b> |                                                                                                  |                                                                                                                                                          |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>          |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. CITY</b>              |                                                                                                                         |                                              |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>---</b>                                                                                                                      |                                                                                                  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                    |                                                                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   | 13e. STREET ADDRESS<br><b>FED. HILL NURSING HOME 21230</b>           |                                                                                                                         |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN EARLES</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |                                                                                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH KEEN UNKNOWN</b>                                                                              |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>NEVER ISSUED</b>                                                                    |                                                                                                  | 17. INFORMANT ADDRESS<br><b>LOUIS H. DIVEN ROOM 31, CITY HALL 100 HOLLIDAY ST. BALTIMORE, MD. 21202</b>                                                  |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PELVIC FRACTURES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>FALL</b> |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>---</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                 |                                                                                                                                                          |                                                                                |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  |                                                                                                                                                | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                   |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                      |  |                                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, IN RESTAURANT, IN TRAM, ETC.)<br><b>Deacon Manor Nursing Home</b> |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>          |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>82</b> , to <b>1/5</b> , 19 <b>83</b> , that (I) (we) last saw the deceased (specify on above, (I) (we) (did) (did not) view the body after death. <b>Natural</b> and that is (my) (our) opinion death occurred on the date and hour and from the causes stated                                         |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 22b. SIGNATURE<br><b>M. McCarthy</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |                                                                                                  | DEGREE<br><b>---</b>                                                                                                                                     |                                                                                |                                                                                              |                                                                                   | 22c. DATE SIGNED<br><b>1/5/83</b>                                    |                                                                                                                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. McCarthy</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                                                                  | 22e. ADDRESS<br><b>3001 S. Hanover ST.</b>                                                                                                               |                                                                                |                                                                                              |                                                                                   |                                                                      |                                                                                                                         |                                              |  |
| 23b. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                | 23b. DATE<br><b>1/7/1983</b>                                                                     |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>             |                                                                                              |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |                                                                                                                         |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>WALTER BROOKS BRADLEY INC., BALTO. MD. 21222</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                                                                  |                                                                                                                                                          |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>1 JAN 11 1983</b>                                        |                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Jan J. Connel</b>                   |                                                                                                                         |                                              |  |



RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

UNIT NO 07218586

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                           |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT MOSELEY EASTMAN</b>                                                                                                                         |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>12</b> YEAR <b>83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>4<sup>35</sup></b> P. M.                                             |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                            |                                                                  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>22</b> YEAR <b>14</b>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hamilton, Ohio</b>                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Brush Mfg.</b>                                                                                                                                    |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>TIMONIUM</b> |  |                                                                                                                                    |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>2214 MIDRIDGE RD. 21093</b>                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>Eastman</b> LAST <b>Eastman</b>                                                                                                         |  |                                                                                                                                    |                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Mai</b> LAST <b>Moseley</b>                                                                         |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 363.10.0897A</b>                                               |                                                                  | 17. INFORMANT<br>ADDRESS<br><b>JEAN P. EASTMAN SAME AS 13e.</b>                                                                                             |  |                                                                                     |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1890

IMMEDIATE CAUSE (a) **Hypertrophoma metastatic to Lung + Bone**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> , 19 <b>82</b> , to <b>1-12</b> , 19 <b>83</b> , that (I) (we) last<br>saw the deceased alive on <b>1-11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Elio Raul Novoa</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elio Raul Novoa</b>                                                                                                                                                                                                                                                                                                           |  |                                                                        |  | 22e. ADDRESS                                                                                                                                         |  |                                                                                                                               |  |

|                                                                                                   |  |                               |  |                                                                                           |  |                                                                     |  |
|---------------------------------------------------------------------------------------------------|--|-------------------------------|--|-------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>CREMATION</b>                                     |  | 23b. DATE<br><b>1/13/1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>                        |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WALTER BROOKS BRADLEY, INC.</b> ADDRESS <b>DUNDALK, MD. 21222</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b> REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |                                                                     |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300857

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |  | 2b. HOUR                                                                                                                |                                              |
| HENRY LEE EDMONDS                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |  | JANUARY 16, 1982                                                                                                                           |  | 3:18 AM                                                                                                                 |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR IF UNDER 72 HRS                                                                                         |                                              |
| male                                                                                                                                                                                                                                                                                                                                                                                                                      | Negro                                                                                                  | 9 8 21                                                                                                                                                   |  | 61 YRS.                                                                                                                                    |  |                                                                                                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                                                                         |                                              |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                                                  | U.S.A.                                                                                                 |                                                                                                                                                          |  | BALTIMORE CITY MD                                                                                                                          |  |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                 | THE JOHNS HOPKINS HOSPITAL                                                                             |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |  | Baltimore                                                                                                                                  |  |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  | 13e. STREET ADDRESS                                                                                                                        |  |                                                                                                                         |                                              |
| Willie Edmonds                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | Sussie Vaughus                                                                                                                                           |  | 1957 Perlman Place 21213                                                                                                                   |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT ADDRESS                                                                                                                      |  |                                                                                                                         |                                              |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 223-22-4544                                                                                                                                              |  | Alice Edmonds 3116 Elleislle Avenue                                                                                                        |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4148<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ischemic heart disease.</u> |                                                                                                        |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 Jan 1983 to 16 Jan 1983, that (I) (we) lost saw the deceased alive on 16 Jan 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                         |                                                                                                        |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | DEGREE                                                                                                                                                   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 22e. ADDRESS                                                                                                                                             |  |                                                                                                                                            |  | 16 Jan                                                                                                                  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 23b. DATE                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 1/20/83                                                                                                                                                  |  | Eastview Mem. Pk.                                                                                                                          |  | Baltimore Co. Md.                                                                                                       |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 25a. DATE RECEIVED                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                                                                         |                                              |
| Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | JAN 21 1983                                                                                                                                              |  | John J. Conner                                                                                                                             |  |                                                                                                                         |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



JAN 2 1963  
JAN 2 1963



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00858

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AARON M. EDMONDSON                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 26, 1983                                                                                              |                                                                                                                                                             |                                                                                   | 2b. HOUR<br>1:20 PM                                                                  |                                                                                                 |                                                                                                                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>W                                                                                                                            |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 25 82                                                                                                               |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>9 MONTHS                                          |                                                                                                 |                                                                                                                                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                                                 |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                      |                                                                                                                                                             |                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE             |                                                                                                 |                                                                                                                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>VA                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 13b. COUNTY<br>CAMPBELL                                                                                                                              |                                                                                                                                                             | 13c. CITY OR TOWN<br>LYNCHBURG                                                    |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       |  |
| 13e. STREET ADDRESS<br>2205 MURRELL RD                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 13f. STREET ADDRESS<br>99999                                                                                                                         |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HOWARD EDMONDSON                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINA MORSE                                                                                          |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>NONE                                                                                                                     |                                                                                                                                                             | 17. INFORMANT<br>HOWARD EDMONDSON                                                 |                                                                                      |                                                                                                 | ADDRESS<br>LYNCHBURG VA                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5728 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hepatic failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hours<br>12 weeks                   |  |                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>GI Bleeding                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                                                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                 |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 18</u> , 19 <u>82</u> , to <u>Jan 26</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>Jan 26</u> , 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 22b. SIGNATURE<br>Alan M Lake MD                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                                                   | 22c. DATE SIGNED<br>Jan 26 1983                                                      |                                                                                                 |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alan M Lake MD                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 22e. ADDRESS<br>Brady Y12 Johns Hopkins Hospital                                                                                                     |                                                                                                                                                             |                                                                                   |                                                                                      |                                                                                                 |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 23b. DATE<br>1-29-83                                                                                                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>CALVARY BAPTIST                             |                                                                                      | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>ZISING SUM CEOR MD                              |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>R. T. FORD FUNERAL HOME MD                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983                                                                                                          |                                                                                                                                                             |                                                                                   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carney                                         |                                                                                                 |                                                                                                                                       |  |



WASHINGTON FIELD OFFICE

MEMPHIS

CHIEF

CAUCD

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 5 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Eliza C. Edwards                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 13 83 |                                                                                                                                                             |  | 2b. HOUR<br>M                                                                                                              |                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>Black                                                                                                                   |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 30 16                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                                |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2916 W. Mosher Street |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                        |                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willie Cromotie                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rachael Cromotie                                                                  |                                                |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>266-07-0678                                                                                            |                                                | 17. INFORMANT<br>ADDRESS<br>Frank Edwards Sr. 2916 W. Mosher St.                                                                                            |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2500 IMMEDIATE CAUSE (a) Chronic Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Diabetes mellitus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 1/13, 1983, that (I) (we) last saw the deceased alive on December 19, 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                                             |  |                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/14/83                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOSES GEBREMARIAM                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>1/18/83                                                                                                               |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.                                                                  |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc.                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                | ADDRESS<br>1101 E. North Avenue                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                                                               |                                              |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                                            |                                              |



20% COTTON 4-11  
CHIEFMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                      |  | REG. NO. 83 00860                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  |
| THELMA                                                                                                                                                                                                                                                                                                                      |  | NEELY                                                                                                  |  | EDWARDS                                                                                                                                                  |  |                                                                     |  | 01 27 83                                                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                      |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7b. HOUR                                                       |  |
| F.                                                                                                                                                                                                                                                                                                                          |  | W.                                                                                                     |  | 05 03 03                                                                                                                                                 |  | 79                                                                  |  | 11 12 M                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                    |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | BALTIMORE CITY                                                      |  | MD.                                                            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                   |  | LUTHERAN HOSPITAL                                                                                      |  |                                                                                                                                                          |  | ACTUARY                                                             |  | LIFE INSURANCE                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. STREET ADDRESS                                                 |  | 13e. ZIP CODE                                                  |  |
| MD.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | BALTO.                                                                                                                                                   |  | OAKLEE VILLAGE APARTMENTS                                           |  | 21229                                                          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                           |  | FIRST MIDDLE LAST                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| JOSEPH B. EDWARDS                                                                                                                                                                                                                                                                                                           |  | GRACE NEELY                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                     |  |                                                                |  |
| NO                                                                                                                                                                                                                                                                                                                          |  | 213033864                                                                                              |  | NEW SMYRNA BEACH, FLORIDA 32069                                                                                                                          |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | DOROTHY COLTON 20 B COUNTRY CLUB DRIVE                                                                                                                   |  |                                                                     |  |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| IMMEDIATE CAUSE (a) 5990 Sepsis, pneumonia                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF UTI, decubitus ulcer                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| (b)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| (c)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                              |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | DATE SIGNED                                                         |  |                                                                |  |
| S. Swanapool                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  | 1/28/83                                                             |  |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| S. Swanapool                                                                                                                                                                                                                                                                                                                |  | Lutheran Hospital, MD                                                                                  |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                                                |  |
| CREMATION                                                                                                                                                                                                                                                                                                                   |  | 01-29-83                                                                                               |  | LOUDON PARK                                                                                                                                              |  | BALTIMORE CITY MARYLAND                                             |  |                                                                |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                   |  | 24b. ADDRESS                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                                                |  |
| HUBBARD FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                                  |  | 4107 WILKENS AVE.                                                                                      |  | 21229                                                                                                                                                    |  | JAN 31 1983                                                         |  |                                                                |  |

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Baltimore City



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 6 1

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ETHEL R. ELIZALDE</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 3, 1983</b>       |                                                                                                 | 2b. HOUR<br><b>02:49AM</b>                                                                       |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>Black</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 15 16</b>                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                               |                                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Stokes</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah cook</b>                                                                                          |                                                                  |                                                                                                 |                                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                                      |                                                                  | 17. INFORMANT ADDRESS<br><b>Major Harris 1606 Kingsway Rd.</b>                                  |                                                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>seizures</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>probable cerebrovascular accident</b> |                                                                                                                                                |                                                                                                                                                             |                                                                  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>10 days</b><br><b>10 days</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                                  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 24, 1982</b> to <b>Jan 3, 1983</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>Jan 3, 1983</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |                                                                                                                                                |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                                  |
| 22b. SIGNATURE<br><b>R Lange MD</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                  | 22c. DATE SIGNED<br><b>JAN 3, '83</b>                                                           |                                                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R LANGE MD</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                               |                                                                  |                                                                                                 |                                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 23b. DATE<br><b>1/7/83</b>                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Pk.</b>     |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. north Avenue</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1983</b>                                                                                                          |                                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Calver</b>                                             |                                                                                                  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 of 3 should be retained by the hospital or attending physician. Page 3 should be destroyed for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-7111.

BP



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FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 6 2

REG. NO.

|                                                                                    |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                       |                                                                    |                                                                                                 |  |
|------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEROY P. ELLEN Sr.</b>                   |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 3 83</b> |                                                                                                                                                             |                                       | 2b. HOUR<br><b>9:55 AM</b>                                         |                                                                                                 |  |
| 3. SEX<br><b>male</b>                                                              |  | 4. RACE<br><b>Black</b>                                                                                                                     |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 27</b>                                                                                                       |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                  |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD. |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                      |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                                                                                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                  |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                       |                                                                    |                                                                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                                      |  |                                                                                                                                             | 13b. COUNTY                                          |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>1758 Montpelier St. 21218</b>                            |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                       |                                                                    |                                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Allen</b>                       |  |                                                                                                                                             |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Gross</b>                                                                                         |                                       |                                                                    |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-20-4737</b>                                                                                              |                                                      | 17. INFORMANT<br>ADDRESS<br><b>Virginia Conigland 1758 Mon tpelier St.</b>                                                                                  |                                       |                                                                    |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Cardiopulmonary Arrest****Acute Pulmonary Edema****Probable Myocardial Infarction 3 hours**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**~ 45 minutes****2 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>83</b> , to <b>1/3</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/3</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) saw the body after death |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Alicia Cool-Foley</b>                                                                                                                                                                                                                                                                                                                           |  | DEGREE<br><b>M.D.</b>                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/3/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br><b>ALICIA COOL-FOLEY, M.D.</b>                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><b>201 E. University Pkwy. Balto. 21218</b>            |  |                                                                                                                                            |  |                                                                                                                            |  |

|                                                                                    |  |                            |  |                                                               |  |                                                                      |  |
|------------------------------------------------------------------------------------|--|----------------------------|--|---------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                      |  | 23b. DATE<br><b>1/7/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. veteran Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. c. march F/H In c. 1101 E. north Avenue</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>            |  |                                                                      |  |
|                                                                                    |  |                            |  | REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                |  |                                                                      |  |



Continued from page 1  
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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 6 3

REG. NO.

104  
FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                          |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Walter William Ellert</i>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                          |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 20, 1983</i>                     |                                                                                      | 2b. HOUR<br><i>10 P.M.</i>                                                                                                 |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><i>White</i>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 28 09</i>                                                                                                        |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>73</i> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto., Md.</i>                                                                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Pimlico Nursing Home</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Cab Driver</i>                               |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                          |                                                                                                                                                             | 13b. COUNTY<br><i>Baltimore</i>                                                    | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ellert</i>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                          |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>                    |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>Yes W.W. II</i>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><i>216-10-0524</i>                                                                                                              | 17. INFORMANT ADDRESS<br><i>Geraldine E. Gizara Box 3585 Annapolis, Md.</i>        |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>4960</i> IMMEDIATE CAUSE (a) <i>cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>severe chronic obstructive pulmonary disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                    |                                                                                                                                          |                                                                                                                                                             |                                                                                    |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)                                                                                                                                                                                                                                                                                                              |                                                                                                                                          |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                          |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                           |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (1) this hospital attended the deceased from <i>1/20</i> 19 <i>83</i> , to <i>1/20</i> 19 <i>83</i> , that (1) <input checked="" type="checkbox"/> I lost<br>saw the deceased alive on <i>1/20</i> 19 <i>83</i> , and that in (my) <input checked="" type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated<br>above. (1) <input type="checkbox"/> I did not view the body after death. |                                                                                                                                          |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><i>N. Cutler MD</i>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                          | DEGREE                                                                                                                                                      |                                                                                    | 22c. DATE SIGNED<br><i>1/22/83</i>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>NAOMI CUTLER</i>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                          | 22e. ADDRESS<br><i>Pimlico Manor Nursing Home</i>                                                                                                           |                                                                                    |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>                                                                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br><i>1-24-83</i>                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Crematorium</i>                                                                                           |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Westview, Balto., Co., Md.</i>      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>C.S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</i>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                          |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 24 1983</i>                                |                                                                                      |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                          |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Coniff</i>                                |                                                                                      |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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October 1943

White  
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1-21-43

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                      |         |                                                                       |  | 8 3 0 0 8 6 4                                                                                                                                               |  |                                                                  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|----------------------------------------------|
| FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                         |         |                                                                       |  | REG. NO.                                                                                                                                                    |  |                                                                  |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                               |         |                                                                       |  | 2a. DATE OF DEATH                                                                                                                                           |  | 2b. HOUR                                                         |                                              |
| Mary Catherine Ellingson                                                                                                                                                                                                                                                                                                                                                          |         |                                                                       |  | 01 08 83                                                                                                                                                    |  | M                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE | 5. DATE OF BIRTH                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                             |  | IF UNDER 1 YEAR                                                  |                                              |
| Female                                                                                                                                                                                                                                                                                                                                                                            | White   | 4 1 1915                                                              |  | 67 YRS.                                                                                                                                                     |  | IF UNDER 24 HRS.                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                         |         | 7b. CITIZEN OF WHAT COUNTRY?                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                  |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                          |         | U.S.A.                                                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                        |  |                                                                  |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                         |         | Baltimore City Hospital                                               |  | Baltimore City MD.                                                                                                                                          |  |                                                                  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                         |         |                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                       |  | Baltimore City Hospital                                                                                                                                     |  | Housewife                                                        |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                       |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                                |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                       |  | Baltimore                                                                                                                                                   |  | Dundalk                                                          |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                            |         |                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                  |                                              |
| Nicholas Regert                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                       |  | Eva Henning                                                                                                                                                 |  |                                                                  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                  |         |                                                                       |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS                                            |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                       |  | 215-10-8701                                                                                                                                                 |  | 3910 Glenhurst Rd. Baltimore, MD. 21222                          |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last. |         |                                                                       |  |                                                                                                                                                             |  |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                |         |                                                                       |  |                                                                                                                                                             |  |                                                                  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                  |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                      |         | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-1</i> 19 <i>82</i> , to <i>11-1</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11-1</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.                              |         | 22b. SIGNATURE<br><i>[Signature]</i>                                  |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><i>1-11-83</i>                               |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                             |         |                                                                       |  | 22e. ADDRESS                                                                                                                                                |  |                                                                  |                                              |
| VENIEDO ALIDIO MD                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                       |  | 7566 Northport Rd Balto. Md 19                                                                                                                              |  |                                                                  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                      |         | 23b. DATE                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                       |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                            |         | 1/12/1983                                                             |  | Oak Lawn                                                                                                                                                    |  | Baltimore Maryland                                               |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                              |         |                                                                       |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                       |                                              |
| Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222                                                                                                                                                                                                                                                                                                                            |         |                                                                       |  | JAN 13 1983                                                                                                                                                 |  | <i>[Signature]</i>                                               |                                              |



General Court

High Court of Justice

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                           |  |                                                                                                        |  | 8 3 0 0 8 6 5                                                                                                                                            |  |                                                                |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | CERTIFICATE OF DEATH                                                                                                                                     |  |                                                                |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                        |  |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | MONTH DAY YEAR                                                                                                                                           |  |                                                                |                                              |
| MIRIAM I ENGEL                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 01-11-83                                                                                                                                                 |  |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                                              |
| Female                                                                                                                                                                                                                                                                                                 |  | White                                                                                                  |  | MONTH DAY YEAR                                                                                                                                           |  | 85 YRS.                                                        |                                              |
| May 16, 1896                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                                              |
| New York                                                                                                                                                                                                                                                                                               |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | BALTIMORE CITY MD.                                             |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| BALTO., CITY                                                                                                                                                                                                                                                                                           |  | St Agnes Hospital                                                                                      |  | Secretary                                                                                                                                                |  | Church                                                         |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                       |                                              |
| Maryland                                                                                                                                                                                                                                                                                               |  | Howard                                                                                                 |  | Elkridge                                                                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13e. STREET ADDRESS                                                                                                                                      |  |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                      |  | FIRST MIDDLE LAST                                                                                      |  | 6101 Downs Ave., Elkridge                                                                                                                                |  |                                                                |                                              |
| late Joseph Kelley                                                                                                                                                                                                                                                                                     |  | late Catherine Carey                                                                                   |  |                                                                                                                                                          |  |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                |                                              |
| No                                                                                                                                                                                                                                                                                                     |  | 108 16 4345                                                                                            |  | M's Florence Loftus 6101 Downs Ave.,                                                                                                                     |  |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4100 IMMEDIATE CAUSE (a) Cardiogenic Shock                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                | 6 hours                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                | 6 hours.                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| Hypertension                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                                                                           |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                        |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-11-83, to 1-11-83, that (I) (we) lost saw the deceased alive on 1-11-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 22b. SIGNATURE George J. Vellani Karan MD                                                                                                                                                                                                                                                              |  |                                                                                                        |  | DEGREE MD                                                                                                                                                |  | 22c. DATE SIGNED 1/11/83                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. VELLANIKARAN MD                                                                                                                                                                                                                                               |  |                                                                                                        |  | 22e. ADDRESS 900 S. Caton Avenue St. Agnes Hospital Baltimore 21228                                                                                      |  |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation                                                                                                                                                                                                                                                    |  | 23b. DATE Jan 12'83                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Maryland   |                                              |
| 24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City                                                                                                                                                                                                                                |  |                                                                                                        |  | 25a. DATE REC'D BY REGISTRAR 1/17/83                                                                                                                     |  |                                                                |                                              |

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71-1-21 1:10 PM

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|--------------------|----------------------------------------------------|-------------|-----------------------------|
| Female             | White                                              | MAY 10 1946 | 23                          |
| New York           | U.S.A.                                             |             |                             |
| CITY               | St James Hospital                                  | Secretary   | Manager                     |
| Maryland           | Howard                                             | Elizabeth   | Oliver Downs Ave. Lexington |
| John Joseph Kelley | John C. Caroline Carey                             |             |                             |
| 23                 | 108 10 4345 N's Florence Frances Oliver Downs Ave. |             |                             |

Grand in 1946  
Viewed Hospital in 1946  
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 6 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edgar R Epes</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1983</b>          |                                                                                                                                                             | 2b. HOUR<br><b>1:50P<sub>M</sub></b>                                                 |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                                       |                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 9 14</b>                                                                                                         |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                    |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.    |                                                                                                                            |                                                                 |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                         |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                               |                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               | 13b. COUNTY<br><b>Baltimore</b>                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                |                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                 | 13e. STREET ADDRESS<br><b>1538 McCulloch St. 21217</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Epes</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Royal</b> |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>218-05-5704</b>                          |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Luther M. Epes 751 N. Avondale Road</b>               |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4329</b> IMMEDIATE CAUSE (a) <b>Intracranial Bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                       |  |                                                                                                                                               |                                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>History of Cerebral vascular accidents.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                         |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                             |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 21, 19 83</b> , to <b>January 25, 19 83</b> , that <input checked="" type="checkbox"/> we last saw the deceased alive on <b>January 25, 19 83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                                                                               |                                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 22b. SIGNATURE<br><b>Richard A. Lane, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><b>1/25/83</b>                                   |                                                                                                                            |                                                                 |                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Lane, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                         | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>                                                                                                        |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>1/28/83</b>                                                                                                                   |                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                                                                                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |                                                                                                                            |                                                                 |                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                                         | ADDRESS<br><b>1101 E. North Avenue</b>                                                                                                                      |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1983</b>                  |                                                                                                                            |                                                                 |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                                                         |                                                                                      |                                                                      |                                                                                                                            |                                                                 |                                                        |  |

BP 22

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                             |  |                                                                                                                                             |                                                   |                                                                                                                                                             |  |                                                                               |  |                                                                                                 |                                        |                                   |  |                                                   |  |
|-------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------|--|---------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLARA BELLE EPPS                                                     |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 07 1983 |                                                                                                                                                             |  | 2b. HOUR<br>7 34 P.M.                                                         |  |                                                                                                 |                                        |                                   |  |                                                   |  |
| 3. SEX<br>FEMALE                                                                                            |  | 4. RACE<br>BLACK                                                                                                                            |                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 10 1905                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                               |                                        | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US                                                                                                          |                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |                                                                                                 |                                        |                                   |  |                                                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hospital |                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>— |                                   |  |                                                   |  |
| 13a. STATE<br>MD                                                                                            |  |                                                                                                                                             |                                                   | 13b. CITY<br>BALTIMORE                                                                                                                                      |  | 13c. CITY OR TOWN<br>BALTIMORE                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                        |                                   |  | 13e. STREET ADDRESS<br>3316 PIEDMONT AVENUE 21216 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM RILEY                                                     |  |                                                                                                                                             |                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA BRAXTON                                                                                            |  |                                                                               |  |                                                                                                 |                                        |                                   |  |                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN |  |                                                                                                                                             |                                                   | 16b. SOCIAL SECURITY NO.<br>21B-22-4572                                                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>CHARLES EPPS AS ABOVE                             |  |                                                                                                 |                                        |                                   |  |                                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary collapse (arrest)  
1536  
DUE TO, OR AS A CONSEQUENCE OF  
(b) sepsis and anemia  
DUE TO, OR AS A CONSEQUENCE OF  
(c) adenocarcinoma of ascending colon.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that <del>the deceased</del> attended the deceased from 12-19 19 83, to 1-7 19 83, that (1) <del>the</del> last saw the deceased alive on 1-7 19 83, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above; (1) <del>the</del> <del>deceased</del> did not view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>STEVEN MATTSON MD                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  | DEGREE<br>MD                                                                   |  | 22c. DATE SIGNED<br>1-7-83                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN MATTSON                                                                                                                                                                                                                                                                                                     |  |                                                                        |  | 22e. ADDRESS<br>3001 SO. HANOVER STREET, BALTO.                                |  |                                                                                                                               |  |

|                                                                   |  |                      |  |                                                        |  |                                              |  |
|-------------------------------------------------------------------|--|----------------------|--|--------------------------------------------------------|--|----------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                         |  | 23b. DATE<br>1-12-83 |  | 23c. NAME OF CEMETERY OR CREMATOR<br>Arbutus Mem. Park |  | 23d. LOCATION<br>BALTIMORE COUNTY            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ 2222 W. North Ave. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983           |  | 25b. REGISTRAR'S SIGNATURE<br>Jan. J. Conner |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James N. Epsilantis                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 19, 1983                           |                                                                                | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>White                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 3, 1929                                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. Gen. Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Delly Ainer | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             | 13b. COUNTY<br>---                                                             | 13c. CITY OR TOWN<br>Baltimore                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nicholas ----- Epsilantis                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna ----- Magoules           |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-24-1613                                                                                      |                                                                                | 17. INFORMANT<br>ADDRESS<br>Mrs. Angela Epsilantis, Same as above              |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Acute Cardio Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Instant<br>years                                                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                      |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                            |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-24, 19 81, to 1-19, 19 83, that (I) (we) last saw the deceased alive on 1-19, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                     |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>Robando V. Goco pro                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br>1-21-82                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robando V. Goco pro                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br>707 E. Fort Ave, Balt. Md.                                     |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 23b. DATE<br>Sat. Jan. 22, 1983                                                                                                                             |                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Orthodox Cemt.                     |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 23e. DATE REC'D. BY REGISTRAR<br>JAN 24 1983                                                                                                                |                                                                                |                                                                                |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 25. REGISTRAR'S SIGNATURE<br>John J. Carish                                                                                                                 |                                                                                |                                                                                |                                                                                                                            |

BP





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 0 8 6 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Verna Mae Ermer                                                                                                                                                                                                                                                                                           |                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/20/83                                   |                                                                                      | 2b. HOUR<br>1:00 A.M.                                                                                                      |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>WHITE                                                                                                           | 5. DATE OF BIRTH MONTH DAY YEAR<br>7/5/28                                                                                                                   |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA, PA.                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                              |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CITY HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                            |                                                                                                                                                             | 13b. COUNTY<br>BALTO.                                                         | 13c. CITY OR TOWN<br>ESSEX                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GROVER                                                                                                                                                                                                                                                                                                                      |                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>INEZ COOPER                                                                                                   |                                                                               |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                         |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>208-22-2422                                                                                                                     |                                                                               | 17. INFORMANT ADDRESS<br>GARY DIEHL SAME AS ABOVE                                    |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1890 IMMEDIATE CAUSE (a) Cardio-respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Renal Cell Carcinoma<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 min                                                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                |                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                                                                                                                            |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/19 19 83, to 1/20 19 83, that (1) (we) lost saw the deceased alive on 1/20 19 83, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                                                    |                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>TV Parran Jr MD                                                                                                                                                                                                                                                                                                                                  |                                                                                                                            | DEGREE<br>MD                                                                                                                                                |                                                                               | 22c. DATE SIGNED<br>1/20/83                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TV PARRAN JR MD                                                                                                                                                                                                                                                                                                           |                                                                                                                            | 22e. ADDRESS<br>BCH Dept of Medicine                                                                                                                        |                                                                               |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                |                                                                                                                            | 23b. DATE<br>JAN 22, 1983                                                                                                                                   |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL                                     |                                                                                                                            |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>MIDDLEBURGH MD MD                                                                                                                                                                                                                                                                                                       |                                                                                                                            | 24. FUNERAL DIRECTOR NAME ADDRESS<br>CONNELLY FUNERAL HOME 300 MACE AVE                                                                                     |                                                                               |                                                                                      |                                                                                                                            |
| 25a. DATE RECEIVED BY REGISTRAR<br>JAN 21 1983                                                                                                                                                                                                                                                                                                                     |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine                                                                                                                |                                                                               |                                                                                      |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                            |                                     |                                                                                                                                                             |                                                      |                                                                                                 |                                                                 |
|----------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sharon Lee Ernst                    |                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 24, 1983 |                                                                                                 | 2b. HOUR<br>3:35P                                               |
| 3. SEX<br>Female                                                           | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 10, 1945                                                                                                         |                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>37 YRS.                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                           | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital                     |                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |                                                                 |
| 12b. KIND OF BUSINESS OR INDUSTRY                                          |                                     |                                                                                                                                                             |                                                      |                                                                                                 |                                                                 |
| 13a. STATE<br>Md.                                                          |                                     | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>Baltimore                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer H. Lambden                 |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Yeakle                                                                                              |                                                      |                                                                                                 |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |                                     | 16b. SOCIAL SECURITY NO.<br>218-44-2219                                                                                                                     |                                                      | 17. INFORMANT<br>ADDRESS<br>Mr. John B. Ernst Sr. Same                                          |                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

2050 IMMEDIATE CAUSE (a) Gram negative Sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Aplastic Anemia

DUE TO, OR AS A CONSEQUENCE OF

(c) Acute Myelogenous Leukemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

12 days

10 months

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                      |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/7, 19 83, to 1/24, 19 83, that (I) (we) last saw the deceased alive on 1/24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>John L. Niles                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                 |  | 22c. DATE SIGNED<br>1/24/83                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John L. Niles                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br>Johns Hopkins Hospital                                 |  |                                                                                      |                                                                                                                            |

|                                                                                  |                            |                                                        |                                                             |
|----------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|-------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                           | 23b. DATE<br>Jan. 27, 1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck Inc. Baltimore, Maryland |                            | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1983           | 25b. REGISTRAR'S SIGNATURE<br>John L. Niles                 |

430:0

2000.2.100

70003

4125

430:0

DATE OF ...

NAME ...

ADDRESS ...



FILED  
FEB 10 1900  
U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                                   |  | 83 00871                                                                                                                                                    |  |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                   |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALVARO ESCOBEDO</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-4-83</b><br>2b. HOUR<br><b>11:06 AM</b>                                                                         |  |                                                                                                                            |                                              |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Hispanic</b>                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-11-42</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Bogota Columbia South America</b>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>COLUMBIA</b>                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>University of Maryland Hospital</b> |  | 12. USUAL OCCUPATION<br>(MOST OF WORKING LIFE)<br><b>Mechanic Maintenance</b>                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Library</b>                                                                        |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md. 20784</b>                                                                                                                                                                                                                                            |  |                                                                                                   |  | 13b. COUNTY<br><b>Prince Geo.</b>                                                                                                                           |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>                                                                                    |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julio Romulo Escobedo</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Aura Marie Noel</b>                                                                                     |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>055 40 4814</b>                                                    |  | 17. INFORMANT<br>ADDRESS<br><b>Maria Teresa Escobedo Same as #13 (Wife)</b>                                                                                 |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4310 IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                 |  |                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:06 P.M. 4 JAN 83</b>                     |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3 JAN 83</b> to <b>4 JAN 83</b> , that (I) (we) lost saw the deceased alive on <b>4 JAN 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Bryan Tropp M.D.</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>4 JAN 83</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRYAN TROPP M.D.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                   |  | 22e. ADDRESS<br><b>22 S. GREENE BALTO., MD. 21201</b>                                                                                                       |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>1/6/83</b>                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery Silver Spring</b>                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Montg. Md.</b>                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis Gasch's Sons Funeral Home, P.A.</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>                                                                                                         |  |                                                                                                                            |                                              |
| ADDRESS<br><b>Hyattsville, Maryland</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                         |  |                                                                                                                            |                                              |

BP

20% COTTON FIBRE

CHICKEN



Francis Jacob's Bone Mineral Bone, T.A.  
Date of Death: 11/11/1911  
Place of Birth: 11/11/1911

027 40 1914

Julia  
Romulo Jacobo  
Julia  
Romulo Jacobo

University of Maryland  
Baltimore City  
Baltimore City

ALVAR 25005-01  
1-4-12 1112



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 8 3 0 0 8 7 2                                                                                                                                               |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>MORRIS</u> <u>ESSROG</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>01-10-83</u>                                                                                                      |  | 2b. HOUR<br>M<br><u>3 PM</u>                                                                                               |  |
| 3. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><u>WHITE</u>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>08-28-1903</u>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>78</u> <u>79</u> YRS.                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>ISRAEL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                |  | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>LEVINDALE HEBREW HOME</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>MANUFACTURER</u>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>FURS</u>                                                                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 13b. COUNTY<br><u>BALTIMORE</u>                                                                                                                             |  |                                                                                                                            |  |
| 13c. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                            |  |
| 13e. STREET ADDRESS<br><u>4001 CLARKS LA. #21215</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 13f. APT. #<br><u>APT. 302</u>                                                                                                                              |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>RABBI NAHUM</u> <u>ESSROG</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>FEIGE</u> <u>UNKNOWN</u>                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><u>064-16-8990</u>                                                                                                              |  |                                                                                                                            |  |
| 17. INFORMANT<br><u>MRS. SADIE ESSROG</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 17. ADDRESS<br><u>4001 CLARKS LA. BALTO., MD</u>                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4439</u> IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MASSIVE CEREBROVASCULAR ACCIDENT</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>ISCHEMIC PERIPHERAL VASCULAR DISEASE</u> <u>YRS.</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>DIABETES MELITUS</u> |  |                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 HRS</u>                                                                                               |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04-16</u> , 19 <u>82</u> , to <u>01-10</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>01-10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN     |  | 22c. DATE SIGNED<br><u>01-10-83</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>B. ZAW-WIN, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  | 22e. ADDRESS<br><u>LEVINDALE HEBREW GERIATRIC 21215</u>                                                                                                     |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><u>JAN. 11, 1983</u>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MIKRO KODESH-BETH ISRAEL</u>                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><u>BALTIMORE</u> <u>MARYLAND</u>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Sol Levinson &amp; Bros</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | ADDRESS<br><u>6000 Reisterstown Rd</u>                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 18 1983</u>                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                            |  |                                                                                                                            |  |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 0 0 8 7 3

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RENA EVANS</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-30-83</b> 19 |  |                                                                                     |  | 2b. HOUR <b>M</b>                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>15</b> YEAR <b>06</b>                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                      |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                             |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                                 |  | 2c. DATE PRONOUNCED DEAD <b>1-30-83</b> 19                                          |  | 2d. HOUR <b>9:58</b> AM                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C arolina</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  |                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |                                                                                        |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                    |  |                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                         |  | 13b. COUNTY                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>1560 Clifton Avenue 21217</b>                                                          |  |                                                                                     |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST <b>Paul</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lydie</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b> |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>246-26-3111</b>                                                                                          |  | 17. INFORMANT ADDRESS<br><b>Eunice Evans 1560 Clifton Avenue</b>                       |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                   |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                         |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                       |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                         |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  |                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                             |  |                                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| ACTUAL SIGNATURE <b>Margareta A. Koroll</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | TITLE (SPECIFY) <b>Assistant</b>                                                                                                        |  |                                                                                        |  | MEDICAL EXAMINER                                                                                                                                            |  |                                                                                                                  |  | DATE SIGNED <b>1-31-83</b>                                                          |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margareta A. Koroll, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  | ADDRESS <b>111 Penn Street</b>                                                                                                          |  |                                                                                        |  |                                                                                                                                                             |  |                                                                                                                  |  |                                                                                     |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  | 23b. DATE<br><b>2/4/83</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>                        |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co,</b> STATE <b>Md.</b>                                |  |                                                                                     |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H Inc.</b> ADDRESS <b>1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                         |  |                                                                                        |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                 |  |                                              |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | REG. NO. 83 00874                                                                                                                                           |  |                                                                                                                         |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>STELLA M EVANS</u>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 16 83                                                                                                                    |  |                                                                                                                         |                                              |
| 3. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE <u>Black</u>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR 10 13 24                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) 58                                                                                      |                                              |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Gaffney, S.C.</u>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City, MD.</u>                                                         |                                              |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY <u>Baltimore</u>                                                                                                      |  | 13c. CITY OR TOWN <u>Baltimore</u>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 13e. STREET ADDRESS <u>1422 Poplar Grove St.</u>                                                                                                                                                                                                                                                                                                          |  | 13f. ZIP CODE <u>21216</u>                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>James Goode</u>                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Louise Rice</u>                                                                     |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO. <u>249-18-9276</u>                                                                                       |  | 17. INFORMANT ADDRESS <u>James C. Evans 1422 Popular Grove St.</u>                                                                                          |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>2000 Cardio-pulmonary arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse Histiocytic Lymphoma</u>                                                      |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>19</u>                                                                                                                                                                                                                |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1983</u> , to <u>January 16, 1983</u> , that (I) (we) last saw the deceased alive on <u>January 16, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <u>Lawrence M. Sigman</u> DEGREE                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 22c. DATE SIGNED                                                                                                                                            |  |                                                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence M. Sigman</u>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 22e. ADDRESS <u>225 Green St. University of Md. Cancer Center</u>                                                                                           |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                   |  | 23b. DATE <u>1/21/83</u>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Md. National Mem. Pk.</u>                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel Md.</u>                                                               |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. varch F/H Inc. 1101 E. North Avenue</u>                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 18 1983</u>                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Lohr</u>                                                                          |                                              |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                  |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  | REG. NO. 00875                                                                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  | 20. DATE KNOWN OF DEATH                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Warren E. Evans                                                                                                                                                                                                                                                                                                                               |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  | 20. DATE KNOWN OF DEATH MONTH DAY YEAR<br>1-30 1983                                                                                |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 17 50                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>32 YRS.                                |  | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                                                                                                  |  | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1-30 1983                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                     |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  |                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |                                                                                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                  |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN<br>Baltimore                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS<br>3521 Gelston Drive 21229                                                                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Donald J. Evans                                                                                                                                                                                                                                                                                                                                              |  |                  |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Betty J. Walston                                   |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                           |  |                  |  | 16b. SOCIAL SECURITY NO.<br>217-52-2775                                                                                            |  | 17. INFORMANT ADDRESS<br>Ernestine Evans 3521 Gelston Dr.                                        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stab wound of chest</u><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                      |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  |                                                                                                  |  |                                                                                                                                                             |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                      |  |                  |  | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR<br>10:35M 1-30 1983                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                          |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>5903 Schering Road, Baltimore City, Md.        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held or death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                 |  |                  |  |                                                                                                                                    |  |                                                                                                  |  |                                                                                                                                                             |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                               |  |                                                                                                  |  | DATE SIGNED<br>1-31-83                                                                                                                                      |  |                                                                                                                                    |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                            |  |                  |  | ADDRESS<br>111 Penn Street, Baltimore, Md.                                                                                         |  |                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | 23b. DATE<br>2/4/83                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.                                           |  |                                                                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville MD                                                                          |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H                                                                                                                                                                                                                                                                                                                                                       |  |                  |  |                                                                                                                                    |  | ADDRESS<br>1101 E. North Ave.                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                       |  |



RECEIVED

DAVID

W. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                     |                                                                                                                                           | 8 3 0 0 8 7 6                        |                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             | REG. NO.                                                            |                                                                                                                                           |                                      |                                                                          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH                                                   |                                                                                                                                           | 2b. HOUR                             |                                                                          |
| FIRST MARY MIDDLE EXAMITAS LAST                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             | MONTH JANUARY DAY 15 YEAR 1983                                      |                                                                                                                                           | 9:55A                                |                                                                          |
| 3. SEX                                                                                                                                                                                                                                                                                                                         | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                                                                                                                           | 7. BALTIMORE CITY OR COUNTY OF DEATH |                                                                          |
| Female                                                                                                                                                                                                                                                                                                                         | White                                                                                                     | June 15, 1904                                                                                                                                               | 78 YRS.                                                             |                                                                                                                                           | Baltimore City MD                    |                                                                          |
| 7. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                                                                           |                                      |                                                                          |
| William Penn, Pa.                                                                                                                                                                                                                                                                                                              | USA                                                                                                       |                                                                                                                                                             | Baltimore City MD                                                   |                                                                                                                                           |                                      |                                                                          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                                                                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY    |                                                                          |
| Baltimore                                                                                                                                                                                                                                                                                                                      | Church Hospital                                                                                           |                                                                                                                                                             | Homemaker                                                           |                                                                                                                                           | Home                                 |                                                                          |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?                                            |                                                                                                                                           | 13e. STREET ADDRESS                  |                                                                          |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk 21222                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                           | 854 Jeannette Ave. 21222             |                                                                          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                            |                                                                                                                                           |                                      |                                                                          |
| FIRST MIDDLE LAST Joseph Norkunsky                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | FIRST MIDDLE LAST Unknown                                           |                                                                                                                                           |                                      |                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)                                                                                                                                                                                                                                                             |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    | 17. INFORMANT                                                       |                                                                                                                                           | ADDRESS                              |                                                                          |
| No                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 162 20 8263                                                                                                                                                 | Evelyn Lawton, Daughter                                             |                                                                                                                                           | Same                                 |                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>5850 IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEVERE METABOLIC ACIDOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CHRONIC RENAL FAILURE                                      |                                                                                                           |                                                                                                                                                             |                                                                     |                                                                                                                                           |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>DAYS<br>YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>NODAL BRADYCARDIA WITH PACEMAKER                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                     |                                                                                                                                           |                                      |                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                     | 20a. AUTOPSY?                                                                                                                             |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?           |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |                                      |                                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |                                      |                                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 14, 19 83, to JANUARY 15, 19 83, that (I) (we) lost saw the deceased alive on JANUARY 15, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                     |                                                                                                                                           |                                      |                                                                          |
| 22b. SIGNATURE<br>XXXXXXXXXXXXX JOHN MANNISI                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                     | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      | 22c. DATE SIGNED<br>1983 JANUARY 15, 1983                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Mannisi MD                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                     | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231                                                   |                                      |                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                |                                                                                                           | 23b. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                     | 23c. LOCATION                                                                                                                             |                                      |                                                                          |
| Burial                                                                                                                                                                                                                                                                                                                         |                                                                                                           | Our Lady of Fatima                                                                                                                                          |                                                                     | Shenandoah, Pa. COUNTY STATE                                                                                                              |                                      |                                                                          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brudzinski Funeral Home PA 1407 Old Eastern Ave                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                     | 25a. DATE REC'D. BY REGISTRAR                                                                                                             |                                      | 25b. REGISTRAR'S SIGNATURE                                               |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                     | JAN 18 1983                                                                                                                               |                                      | John J. Casier                                                           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                          |                                                                                                                                                            |                                                                              |                                                                                          |                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA ELIZABETH FACKETT                                                                                                                                                                                                                                                                                                                      |                                                                                                                                          |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 21, 1983                       |                                                                                          | 2b HOUR<br>4:45 A.M.                                                                                                      |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE<br>White                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 1911                                                                                                            |                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                |                                                                                                                           |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                         |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland                                                                                                                                                                                                                                                              |                                                                                                                                          |                                                                                                                                                            | 13b COUNTY<br>Baltimore                                                      | 13c CITY OR TOWN<br>Edgemere                                                             | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Koporec                                                                                                                                                                                                                                                                                                                             |                                                                                                                                          |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Tekla Koporec               |                                                                                          |                                                                                                                           |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                             |                                                                                                                                          | 16b SOCIAL SECURITY NO.<br>213-12-0986                                                                                                                     |                                                                              | 17 INFORMANT<br>ADDRESS<br>8612 Oak Road<br>Balto., MD. 21219                            |                                                                                                                           |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) METASTATIC <del>BARX</del> CARCINOMA OF COLON<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                          |                                                                                                                                                            |                                                                              |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                               |                                                                                                                                          |                                                                                                                                                            |                                                                              |                                                                                          |                                                                                                                           |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                          | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                              | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |                                                                                                                                          | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                              | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)             |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |                                                                                                                                          | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                                                                           |                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                                                                                                                           |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 17, 19 83, to JANUARY 21, 19 83, that (I) (we) last saw the deceased alive on JANUARY 21, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                               |                                                                                                                                          |                                                                                                                                                            |                                                                              |                                                                                          |                                                                                                                           |
| 22b SIGNATURE<br>Paul Gormley                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                          | DEGREE<br>MD                                                                                                                                               |                                                                              | 22c. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MARYLAND 21231 |                                                                                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL GORMLEY M.D.                                                                                                                                                                                                                                                                                                                        |                                                                                                                                          | 22e ADDRESS                                                                                                                                                |                                                                              | 22f. DATE SIGNED<br>1/21/83                                                              |                                                                                                                           |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | 23b DATE<br>1/24/1983                                                                                                                                      |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge                                        |                                                                                                                           |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland                                                                                                                                                                                                                                                                                                              |                                                                                                                                          | 23e. DATE REC'D. BY REGISTRAR<br>JAN 24 1983                                                                                                               |                                                                              | 23f. REGISTRAR'S SIGNATURE<br>John J. Corbett                                            |                                                                                                                           |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222                                                                                                                                                                                                                                                                                    |                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1983                                                                                                               |                                                                              |                                                                                          |                                                                                                                           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  | 8 3 0 0 8 7 8                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                    |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                          |  | FIRST                                                                                                                                                       |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                             |  | 2b. HOUR                                     |  |
| LEO H. FAIT                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  | January 23, 1983                                                                             |  | 9:45 AM                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | IF UNDER 1 YEAR MONTHS DAYS                                                                  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                                                                       |  | Feb. 3, 1897                                                                                                                                             |  | 85 YRS.                                                                                                                 |  |                                                                                              |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |                                                                                              |  |                                              |  |
| MD                                                                                                                                                                                                                                                                                                                                                                        |  | USA                                                                                                                                                         |  |                                                                                                                                                          |  | Baltimore City MD.                                                                                                      |  |                                                                                              |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                      |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                 |  | Hamilton Nursing Home                                                                                                                                       |  |                                                                                                                                                          |  | Secretary - Dietrich Bros.                                                                                              |  |                                                                                              |  |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                   |  | 13a. STATE                                                                                                                                                  |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                             |  | Baltimore                                                                                                                                                |  |                                                                                                                         |  |                                                                                              |  | 2904 Kildaire Drive 21234                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| Leo Fait                                                                                                                                                                                                                                                                                                                                                                  |  | Kate Fulton                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                                 |  |                                                                                              |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                        |  | 212 01 6518                                                                                                                                                 |  | Mrs. Mildred D. Fait,                                                                                                                                    |  | Same                                                                                                                    |  |                                                                                              |  |                                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4850 IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____            |  |                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Senile Dementia</u>                                                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                              |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JAN 19</u> , 19 <u>83</u> , to <u>JAN 23</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>JAN 21</u> , 19 <u>83</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (1) (did not) view the body after death. |  |                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 22b. SIGNATURE <u>Howard Bond</u>                                                                                                                                                                                                                                                                                                                                         |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>1/24/83</u>                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| Dr. Howard Bond, M. D.                                                                                                                                                                                                                                                                                                                                                    |  | 9618 Belair Road, Balto., MD                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                              |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                                                                              |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                    |  | 1/26/83                                                                                                                                                     |  | Moreland Memorial                                                                                                                                        |  | Balto. Co., MD                                                                                                          |  |                                                                                              |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                 |  | 24b. ADDRESS                                                                                                                                                |  | 25a. DATE REC'D BY REGISTRAR                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |                                                                                              |  |                                              |  |
| Henry W. Jenkins & Sons Co.                                                                                                                                                                                                                                                                                                                                               |  | 4905 York Road Balto., MD 21212                                                                                                                             |  | JAN 25 1983                                                                                                                                              |  | <u>John J. Cahill</u>                                                                                                   |  |                                                                                              |  |                                              |  |

BP

10/1/83

MD

Dr. Howard Ford, M.D.,  
c/o 5010 Road, Suite 200, MD

Special  
10000 Motel on Memorial Park, Co.,

Henry W. Jenkins & Son, Co.,

York Road, Baltimore, MD

*Handwritten signature*

MD

*General Director*

*General Director*

Dr. Howard Ford, M.D.,  
c/o 5010 Road, Suite 200, MD

10000 Motel on Memorial Park, Co.,

Henry W. Jenkins & Son, Co.,

York Road, Baltimore, MD

Special  
10000 Motel on Memorial Park, Co.,

Dr. Howard Ford, M.D.,  
c/o 5010 Road, Suite 200, MD

10/1/83



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 342-3500.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  | REG. NO.                                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BRONNIE B. FEASTER</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>21</b> YEAR <b>83</b>                                |  | 2b. HOUR<br><b>3:59a M</b>                                                                                                                 |  |                                                                                                                               |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>BLACK</b>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>17</b>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                                                                             |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY!</b> MD.                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                                                                                                                               |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                              |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>522 N. PULASKI ST. 21223</b>                                                                                     |  |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST <b>WALTER</b> MIDDLE <b></b> LAST <b>BENNETT</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b></b> LAST <b>DIGGS</b>                                                                              |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT<br>ADDRESS<br><b>NELSON BENNETT 522 N. PULASKI ST. 21223</b>                      |  |                                                                                                                                            |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>heart attack</b>                                                                                                                                                                                                 |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                                                                            |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DOA</b> , 19 <b></b> , to <b>1/19</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Scott R. Zuga, MD</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/25/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCOTT R. ZUGA</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>Greater Balto Med. Center</b>                                                                                                            |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | 23b. DATE<br><b>1-26-83</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>                                |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b></b> STATE <b>MARYLAND</b>                                                        |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Council</b>                                                                                       |  |                                                                                                                               |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                  |  |                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH (NMN) FEIBEL                                                                       |  | 2a. DATE OF DEATH<br>1/24/83                                                                                                                                                                                                                                                               |  | 2b. HOUR<br>2:31 P.M.                                                                                                                                       |  |
| 3. SEX<br>Male                                                                                                                   |  | 4. RACE<br>White                                                                                                                                                                                                                                                                           |  | 5. DATE OF BIRTH<br>Dec. 19, 1912                                                                                                                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>70                                                                                            |  | 7. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                             |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. of M. D. Hosp -                             |  |
| 12a. USUAL OCCUPATION<br>Millman                                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber Co.                                                                                                                                                                                                                                            |  | 13. STREET ADDRESS<br>(21144)<br>863 Elmhurst Road                                                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nickolaus Feibel                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susanna Schere                                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO.<br>215-03-1699                                                                                                                      |  |
| 17. INFORMANT (wife)<br>Mrs. Susanna M. Feibel                                                                                   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Respiratory arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HT or H.E. -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Intracerebral hematoma - |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: |  |                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                             |  |

## MEDICAL CERTIFICATION

|                                                                        |  |                                                                                |  |                                                                           |  |                                                                                                                            |  |
|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>1/1/83                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Intracerebral hematoma.    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. DATE SIGNED<br>1/24/83                                                    |  | 21g. DATE SIGNED<br>1/24/83                                               |  | 21h. DATE SIGNED                                                                                                           |  |
| 21i. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Machado                       |  | 21j. ADDRESS<br>U. of M. D. Hosp -                                             |  | 21k. DATE SIGNED<br>1/24/83                                               |  | 21l. DATE SIGNED                                                                                                           |  |

|                                                         |  |                                 |  |                                                           |  |                                                                      |  |
|---------------------------------------------------------|--|---------------------------------|--|-----------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 22a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 22b. DATE<br>28 Jan. 83         |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk. |  | 22d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A., MD. |  |
| 23a. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home |  | 23b. ADDRESS<br>Glen Burnie MD. |  | 23c. DATE REC'D. BY REGISTRAR<br>JAN 25 1983              |  | 23d. REGISTRAR'S SIGNATURE                                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's representative should be notified.



CHIEF

20% CUT

EXHIBIT  
100-100000-100000

EXHIBIT 100-100000-100000  
100-100000-100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 8 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                   |  |                                                                                                                                                     |                                                                |                                                                                                                                                             |                                                                                                    |                                                                                    |                                                                                                 |                                                             |                                                                         |  |
|-----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT</b>                              |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 25, 1983</b> |                                                                                                                                                             |                                                                                                    | 2b. HOUR<br><b>12:10A<sup>M</sup></b>                                              |                                                                                                 |                                                             |                                                                         |  |
| 3. SEX<br><b>MALE</b>                                                             |  | 4. RACE<br><b>WHITE</b>                                                                                                                             |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 27, 1904</b>                                                                                             |                                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>                                       |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b> |                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                       |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                    | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD            |                                                                                                 |                                                             |                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7011 PARK HEIGHTS AVE. APT. 3-C</b> |                                                                |                                                                                                                                                             |                                                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>REALTOR</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>     |                                                                         |  |
| 13a. STATE<br><b>MARYLAND</b>                                                     |  |                                                                                                                                                     | 13b. COUNTY<br><b>BALTIMORE</b>                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                              |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             | 13e. STREET ADDRESS<br><b>21215<br/>7011 PARK HEIGHTS AVE. APT. 3-C</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISRAEL FELDSTEIN</b>                 |  |                                                                                                                                                     |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA UNKNOWN</b>                                                                                         |                                                                                                    |                                                                                    |                                                                                                 |                                                             |                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>215-03-4708</b>                 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>APT. 3-C (21215)<br/>MRS. ROSE FELDSTEIN 7011 PARK HEIGHTS AVE.</b> |                                                                                    |                                                                                                 |                                                             |                                                                         |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4029** DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) **HAS CVD + CVD**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Approx.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

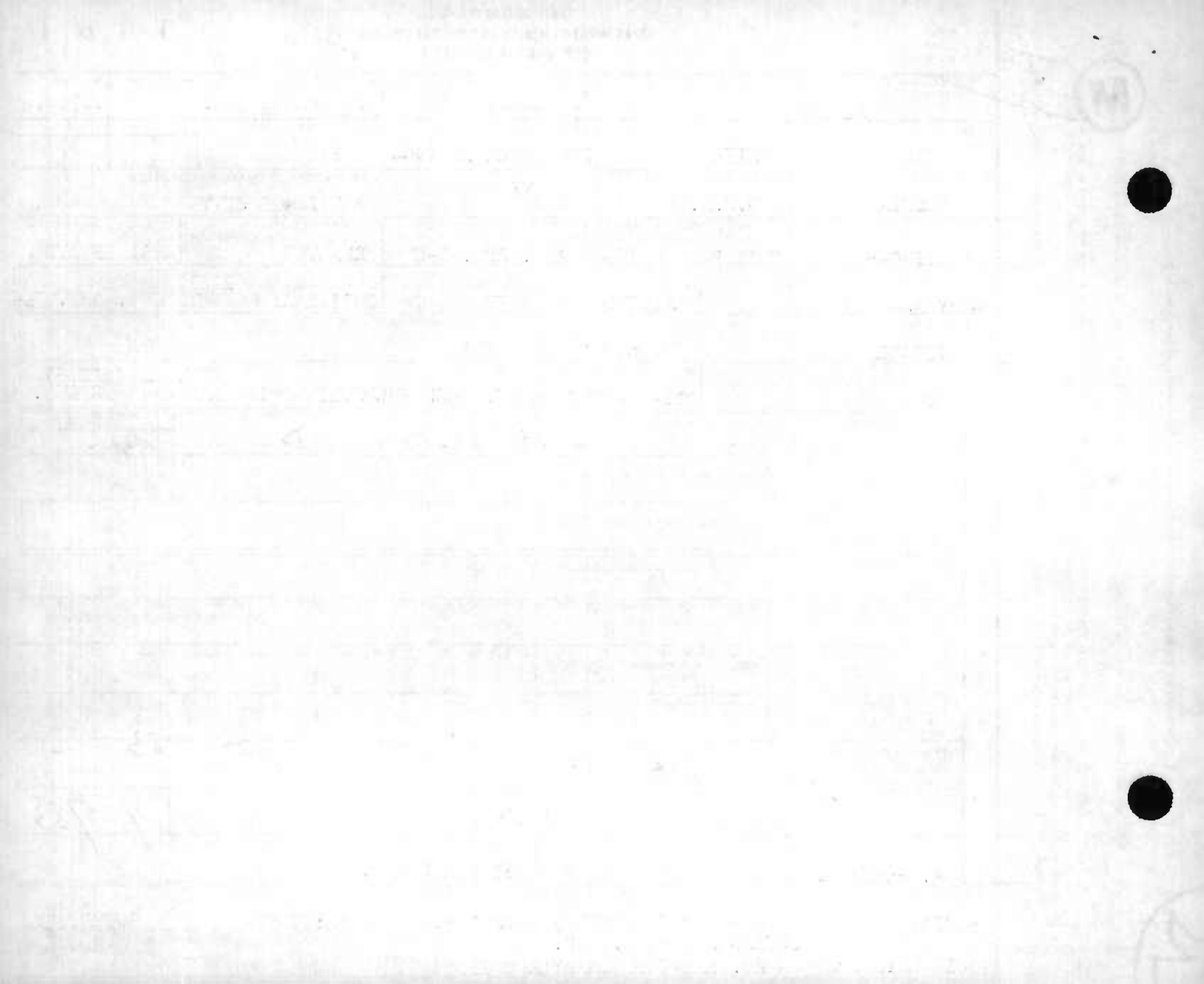
|                                                                                                                                                                                                                                                                                                                              |  |                                                                        |  |                                                                                                                                                        |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                         |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/25/83</b> to <b>1/27/83</b> , that (I) (we) last saw the deceased alive on <b>1/25/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                        |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>DR. BORIS KERZNER</b>                                                                                                                                                                                                                                                                                   |  |                                                                        |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/25/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. BORIS KERZNER</b>                                                                                                                                                                                                                                                            |  |                                                                        |  | 22e. ADDRESS<br><b>131 SLADE AVE.</b>                                                                                                                  |  |                                                                                                                            |  |

|                                                                                                                                   |  |                             |  |                                                               |  |                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|---------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                     |  | 23b. DATE<br><b>1-26-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and any



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                               |  |                                                                                      |  | REG. NO. 8300882                                                                                                           |  |                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN FELLER</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-12-83</b>                                                                                                              |  |                                                                                      |  | 2b. HOUR<br><b>2:05 A</b>                                                                                                  |  |                                                    |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>White</b>                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 11 04</b>                                                                                                               |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>78</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |  |                                                                                                                            |  |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Sam. Hosp.</b> |  |                                                                                                                                                                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hardware</b>                                                                       |  |                                                    |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                        |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1125 Ramblewood Road 21239</b>                                                                   |  |                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick S. Feller</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Guinan</b>                                                                                               |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>073-07-5729</b>                                                       |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Marie Feller Balto., Md. 1125 Ramblewood Rd.</b>                                                                               |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Squamous cell CA of Lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                     |  |                                                                                                                                                                    |  |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                            |  |                                                                                                                                     |  |                                                                                                                                                                    |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |                                                                                                                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                     |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                  |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-18-1982</b> to <b>1-12-1983</b> , that (I) (we) lost saw the deceased alive on <b>1-12-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |  |                                                                                                                                     |  |                                                                                                                                                                    |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 22b. SIGNATURE<br><b>Anil N. Raiker</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                      |  | 22c. DATE SIGNED<br><b>1-12-83</b>                                                                                         |  |                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANIL - N. RAIKER MD.</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL</b>                                                                                                                     |  |                                                                                      |  |                                                                                                                            |  |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>1/12/83</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                 |  |                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |  |                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  | ADDRESS<br><b>Balto., Md.</b>                                                                                                                                      |  |                                                                                      |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 17 1983</b>                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sam J. Ganiel</b> |  |

BP





CHIEF

17/3/83

removed

John J. ...

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 8 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                      |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LOUIS G. FERRARI Sr.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 6 83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>8<sup>25</sup> P<sup>M</sup></b>                                                 |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 20, 1913</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>IF UNDER 24 HRS.</b>                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                      |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mailer</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>                                                                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>21239</b>                                                                                                                 |                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1228 Meridene Dr. 21239</b>                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Natale Ferrari</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Raphaeline Lodisi</b>                                                                                   |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. LL 215-03-8044</b>                                                                                      |                                                      | 17. INFORMANT<br><b>Sanata T. Ferraril</b>                                                                                                                  |  | ADDRESS<br><b>21239 1228 Meridene Dr.</b>                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1990 IMMEDIATE CAUSE (a) Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                             |                                                      |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Emphysema</b>                                                                                                                                                                                                        |  |                                                                                                                                             |                                                      |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                      |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-28-82</b> to <b>1-6-83</b> , that (I) (we) last saw the deceased alive on <b>1-6-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.                                 |  |                                                                                                                                             |                                                      |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Anna Ferrari</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                      | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR        |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>1. 6. 1983.</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANNA FERRARI</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                      | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>Jan. 10, '83</b>                                                                                                            |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Gar. Balto. Co., MD</b>                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                      | ADDRESS<br><b>8521 Loch Raven Blvd.</b>                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                        |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  | REG. NO. 00884                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  |                                                                                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BENJAMIN WOOD FIELD                                                                                                                                                                                                                                                                                                                                                                   |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 22 1983 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>White                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 15, 1905                                                                                                         |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br>77                                                 |  | IF UNDER 1 YR. MONTHS DAYS                                                                      |  | IF UNDER 24 HRS. HOURS MIN.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  | 2c. DATE PRONOUNCED DEAD<br>1 23 1983                                                           |  | 2d. HOUR<br>12:07                                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3501 St. Paul St. - 21218                     |  |                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Underwriter-Md. Casualty Rtrd. |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                     |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  |                                                                                                      |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                            |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Apt. #610<br>3501 St. Paul Street - 21218                                |  |                                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel S. Field                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Wood Crook                               |  |                                                                                                 |  |                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes X                                                                                                                                                                                                                                                                                                                                                                 |  |                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II 217-07-4753                                                                              |  | 17. INFORMANT ADDRESS<br>-21201<br>Samuel S. Field, III, Esq. - 9 W. Hamilton St.               |  |                                                                                                 |  |                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>4960 IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                    |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                            |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  |                                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                 |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |                                                                                                 |  |                                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                 |  |                                                                                                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                 |  |                                                                                                      |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                        |  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                                           |  |                                                                                                 |  | DATE SIGNED<br>1-23-83                                                                          |  |                                                                                                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                       |  |                                        |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                                                  |  |                                                                                                 |  |                                                                                                 |  |                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |  | 23b. DATE<br>Jan. 24, 1983                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematorium                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. 21202                              |  |                                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry Sander & Sons, Inc., Balto., Md. 21213                                                                                                                                                                                                                                                                                                                                                                   |  |                                        |  |                                                                                                                                                             |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 3 1983                                                      |  | 26. REGISTRAR'S SIGNATURE<br>                                                                   |  |                                                                                                      |  |

Handwritten notes and faint printed text, mostly illegible due to fading and bleed-through. Some visible fragments include "1962", "1961", and "1960".

Handwritten notes and faint printed text at the bottom of the page. A circular stamp is visible on the left side, and a date stamp "FEB 1962" is visible on the right side.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                         |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERNARD P. FILIPPI</b>                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                         | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1-28-83</b> DAY <b>19</b> YEAR <b>19</b> |                                                                                                                                               |                                               | 2b. HOUR <b>4:50</b>                                                                         |                                                                                     |                                                 |
| 3. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE <b>W</b> | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>96</b>                         | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>86</b> YRS.                                                             | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>                                                                                                 | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> | 2c. DATE PRONOUNCED DEAD <b>1-28-83</b> DAY <b>19</b> YEAR <b>19</b>                         |                                                                                     |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>                                                                                                                                                                                                                                                                                                                                                                               |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                 |                                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                   |                                                                                     |                                                 |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Union Memorial Hospital</b> |                                                                                                               |                                                                                                                                               |                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>           |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b> |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                         | 13b. COUNTY <b></b>                                                                                           | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                            |                                               | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                     |                                                 |
| 14. FATHER'S NAME<br>FIRST <b>Peter</b> MIDDLE <b></b> LAST <b>Filippi</b>                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Katherine</b> MIDDLE <b></b> LAST <b>?</b>                               |                                                                                                                                               |                                               | 13e. STREET ADDRESS <b>3036 Abell Ave. 21218</b>                                             |                                                                                     |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                          |                  | 16b. SOCIAL SECURITY NO. <b>215 05 2273</b>                                             |                                                                                                               | 17. INFORMANT <b>Mrs. Mabel C. Filippi,</b>                                                                                                   |                                               | ADDRESS <b>Same</b>                                                                          |                                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subdural hematoma</b><br><b>8880</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>(c) <b></b>                                                                                                                                 |                  |                                                                                         |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                         |                  |                                                                                         |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |                                                                                                               |                                                                                                                                               |                                               |                                                                                              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |                  | 21b. TIME OF INJURY <b>12:00 PM</b> MONTH <b>1</b> DAY <b>27</b> YEAR <b>83</b>         |                                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>subject fell while walking</b>                               |                                               |                                                                                              |                                                                                     |                                                 |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>               |                                                                                                               | 21f. LOCATION <b>412 E. 31st Street</b> CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Maryland</b> STATE <b>MD</b>                                 |                                               |                                                                                              |                                                                                     |                                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                         |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     |                                                 |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                            |                  | TITLE (SPECIFY) <b>Assistant</b>                                                        |                                                                                                               |                                                                                                                                               |                                               |                                                                                              | DATE SIGNED <b>1-29-83</b>                                                          |                                                 |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |                  | ADDRESS <b>111 Penn Street</b>                                                          |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                |                  | 23b. DATE <b>1/31/83</b>                                                                |                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>                                                                                       |                                               |                                                                                              | 23d. LOCATION CITY OR TOWN <b>Balto.,</b> COUNTY <b>MD</b> STATE <b>MD</b>          |                                                 |
| 24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                         |                                                                                                               | 25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1983</b>                                                                                              |                                               | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                                             |                                                                                     |                                                 |
| 4905 York Road Balto., MD 21212                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                         |                                                                                                               |                                                                                                                                               |                                               |                                                                                              |                                                                                     |                                                 |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                        |  |                                                                                               |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                            |  | FIRST<br>ANNA                                                                                                                  |  | MIDDLE<br>A.                                                                                                                                                |  | LAST<br>FINKE                                                          |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR    |  | 2b. HOUR<br>M                                                                                   |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 5, 1911                                                                                                          |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>71 YRS.                          |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                      |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY YEAR<br>1 9 19 83                                   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Clerk Ret. Mercy Hospital |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>MD                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6513 Harford Rd. |  | 13a. STATE<br>Maryland                                                                                                                                      |  | 13b. COUNTY<br>Baltimore                                               |  | 13c. CITY OR TOWN<br>Baltimore                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Casimir Keydash                                                                                                                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Milinausky                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-03-0001 |  | 17. INFORMANT<br>ADDRESS<br>Harry B. Finke Jr. 13400 Blythenia Rd.                            |  | 17. ADDRESS<br>Phoenix, Md 21131                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                        |  |                                                                                               |  |                                                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                        |  |                                                                                               |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                        |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                                                                                                 |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                 |  |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                                                              |  |                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                             |  |                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                        |  |                                                                                               |  |                                                                                                 |  |
| ACTUAL<br>SIGNATURE<br><i>Thomas D. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  | TITLE (SPECIFY)<br>Deputy Chief                                                                                                                             |  |                                                                        |  | MEDICAL EXAMINER<br>DATE<br>SIGNED 1-10-83                                                    |  |                                                                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                                                  |  |                                                                        |  |                                                                                               |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  | 23b. DATE<br>Jan 12 1983                                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.               |  |                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                |  |                                                                                                                                                             |  | ADDRESS<br>Baltimore, Maryland                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983                                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canfield</i>                                           |  |



RECEIVED  
JAN 11 1951  
U.S. AIR FORCE  
HONOLULU

TO: SAC, HONOLULU (100-100000)  
FROM: SAC, SAN FRANCISCO (100-100000)  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or letter body.]

BP \_\_\_\_\_  
 DHMH - 16 50M 1/81  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession by the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  | 8 3 0 0 8 8 7                                                                                                                                               |  |                                                                                                                            |                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                                                                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George W. Finnerty</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/16/83</b>                                                                                                       |  | 2b. HOUR<br><b>7:40 P.M.</b>                                                                                               |                                                                                    |
| 3. SEX<br><b>White Male</b>                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 30 28</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                                                          |                                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                                              |                                                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>truck driver</b>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                            |                                                                                    |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>BALT</b>                                                                                                                  |  | 13c. CITY OR TOWN<br><b>BALT</b>                                                                                                                            |  | 13e. STREET ADDRESS<br><b>1213 Tennant Wy 21224</b>                                                                        |                                                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas L. FINNERTY</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARLOTTE REITZ</b>                                                                                     |  |                                                                                                                            |                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO<br><b>WN II 218-18-0473</b>                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>HELEN L. FINNERTY 1213 TENANT WAY BALTO. 24</b>                                                                              |  |                                                                                                                            |                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>possible myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                          |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one hour</b><br><b>one hour</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a)                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                              |  |                                                                                                                            |                                                                                    |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                                                                    |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 16</b> 19 <b>83</b> , to <b>Jan 16</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>Jan 16</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                    |
| 22b. SIGNATURE<br><b>Mark E. Unis MD</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/16/83</b>                                                                                         |                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK E. UNIS MD.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>Dept of Dermatology 600 N. Wolfe St BALTO 21205</b>                                                                                      |  |                                                                                                                            |                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><input checked="" type="checkbox"/>                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                                            |                                                                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER DABROWSKI</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  | ADDRESS<br><b>1005 DUNDALK AV</b>                                                                                                                           |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 21 1983</b>                                                                         |                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                         |  |                                                                                                                            |                                                                                    |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP-3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 8 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 2a. DATE OF DEATH                                                                                      |  |  | MONTH DAY YEAR                                                                                                                                              |  |  | 2b. HOUR P                                                     |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | FIRST MIDDLE LAST                                                                                      |  |  | January 29, 1983                                                                                                                                            |  |  | 5:15 M                                                         |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 4. RACE                                                                                                |  |  | 5. DATE OF BIRTH                                                                                                                                            |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                                              |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | WHITE                                                                                                  |  |  | MONTH DAY YEAR<br>July 17 1904                                                                                                                              |  |  | 78 YRS.                                                        |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                                              |  |
| MICHIGAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  | U.S.A.                                                                                                 |  |  |                                                                                                                                                             |  |  | Baltimore City MD.                                             |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | Maryland General Hospital                                                                              |  |  | MACHINIST                                                                                                                                                   |  |  | CROWN, CORK & SEAL                                             |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 13b. COUNTY                                                                                            |  |  | 13c. INSIDE CITY LIMITS?                                                                                                                                    |  |  | 13e. STREET ADDRESS                                            |                                              |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | -                                                                                                      |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  |  | 244 S. ROBINSON ST. 21224                                      |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |  |                                                                                                                                                             |  |  |                                                                |                                              |  |
| FIRST MIDDLE LAST<br>RAYMOND FIORUCCI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | FIRST MIDDLE LAST<br>ROSA RONCONI                                                                      |  |  |                                                                                                                                                             |  |  |                                                                |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 16b. SOCIAL SECURITY NO.                                                                               |  |  | 17. INFORMANT                                                                                                                                               |  |  | ADDRESS                                                        |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 213-01-0804                                                                                            |  |  | CLARA FIORUCCI (WIFE)                                                                                                                                       |  |  | SAME ADDRESS                                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>0384</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Urinary tract infection/Hypotension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Possible gram-negative Sepsis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral Arteriosclerosis</u> |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?                                                                                                                                               |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                        |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |  |                                                                |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |                                                                |                                              |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>January 28</u> , 19 <u>83</u> , to <u>January 29</u> , 19 <u>83</u> , that X (we) last saw the deceased alive on <u>January 29</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                |                                              |  |
| 22b. SIGNATURE<br><u>Karen Trent MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                        |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  | 22c. DATE SIGNED<br><u>1/29/83</u>                             |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Karen Trent, M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                        |  |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |  |  |                                                                |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 23b. DATE                                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 2/2/83                                                                                                 |  |  | SACRED HEART OF JESUS BALTO.                                                                                                                                |  |  | MD.                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>SCHIMUNEK FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                        |  |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 1 1983                                                                                                                  |  |  |                                                                |                                              |  |

MEDICAL CERTIFICATION



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January 2

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FEB 1 1977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2300.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | REG. NO.<br>8300889 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR                                                                                        |  | 2b. HOUR<br>MIN.    |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  | William Edward Fisher                                                                           |  | 11/1/83                                                                                                                    |  | 6:17 PM             |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  | IF UNDER 24 HRS.    |  |
| Male                                                                                                                                                                                                                                                                                                                                                                  |  | White                                                                                                     |  | 10/18/04                                                                                                                                                    |  | 78                                                                                              |  |                                                                                                                            |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                                                                                                                            |  |                     |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                              |  | USA                                                                                                       |  |                                                                                                                                                             |  | Baltimore City MD                                                                               |  |                                                                                                                            |  |                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                     |  |
| Baltimore City                                                                                                                                                                                                                                                                                                                                                        |  | Sinai Hospital                                                                                            |  |                                                                                                                                                             |  | Repair Service                                                                                  |  | Telephone                                                                                                                  |  |                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                        |  |                     |  |
| MD                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | Baltimore                                                                                                                                                   |  |                                                                                                 |  | 4200 EASA TER. 21211                                                                                                       |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                   |  |                                                                                                                            |  |                     |  |
| William T. J. Fisher                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  | Rachel Parrish                                                                                  |  |                                                                                                                            |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                                         |  |                                                                                                                            |  |                     |  |
| No                                                                                                                                                                                                                                                                                                                                                                    |  | 212 03 6809                                                                                               |  | Belm forum                                                                                                                                                  |  | Kathryn M. Fisher same                                                                          |  |                                                                                                                            |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>83</u> , to <u>1/1</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| 22b. SIGNATURE<br><u>Allen Hottelmann</u>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><u>1/1/83</u>                                                                                          |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen Hottelmann</u>                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 22e. ADDRESS<br><u>Sinai Hospital</u>                                                                                                                       |  |                                                                                                 |  |                                                                                                                            |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |  |                     |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                |  | 1/4/83                                                                                                    |  | Druid Ridge Cemetery                                                                                                                                        |  | Pikesville, Balto. Co. Md                                                                       |  |                                                                                                                            |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                   |  | 25b. REGISTRAR'S SIGNATURE                                                                                                 |  |                     |  |
| Burgee Funeral Home, 3631 Falls Road 21211                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  | JAN 3 1983                                                                                      |  | <u>John J. Conard</u>                                                                                                      |  |                     |  |

BP



11/13/68

Special Service Laboratory

Michael J. Ladd

William T. Ladd

Lab. No. 100-100000

Lab. No. 100-100000

100-100000

Lab. No. 100-100000

Lab. No. 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16-50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | 8 3 0 0 8 9 0                                |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | REG. NO.                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANITA FITZGERALD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 26, 1983</b>                                  |  |                                                                                                                            |  | 2b. HOUR<br><b>7:20 AM</b>                   |  |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 - 26 - 30</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |                                                                                                                            |  |                                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                              |  |  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1808 N. Register Street</b> 21213                                                                |  |                                              |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Horace Gladsey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Stokes</b>                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>219-12-9827</b>                                                                                           |  | 17. INFORMANT<br><b>Russell Fitzgerald</b>                                                                                                                  |  | ADDRESS<br><b>1808 N. Register St.</b>                                                          |  |                                                                                                                            |  |                                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC ADENOCARCINOMA TO LIVER</b><br>(c) <b>ANEMIA, BILATERAL PLEURAL EFFUSION</b>                                                                                                                                        |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from <b>JANUARY 3</b> , 19 <b>83</b> , to <b>JANUARY 26</b> , 19 <b>83</b> , that (I <input checked="" type="checkbox"/> last saw the deceased alive on <b>JANUARY 23</b> , 19 <b>83</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input type="checkbox"/> we <input type="checkbox"/> did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 22b. SIGNATURE<br><i>Mukesh Luhar</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>1/26/83</b>                                                                                         |  |                                              |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MUKESH LUHAR, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY, BALTIMORE, MD 21231</b>                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>1-29-83</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ONNE Arunde Co., Md.</b>                       |  |                                                                                                                            |  |                                              |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>William J. Spivey</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                             |  |                                                                                                                            |  |                                              |  |  |  |

MEDICAL CERTIFICATION



100% COTTON



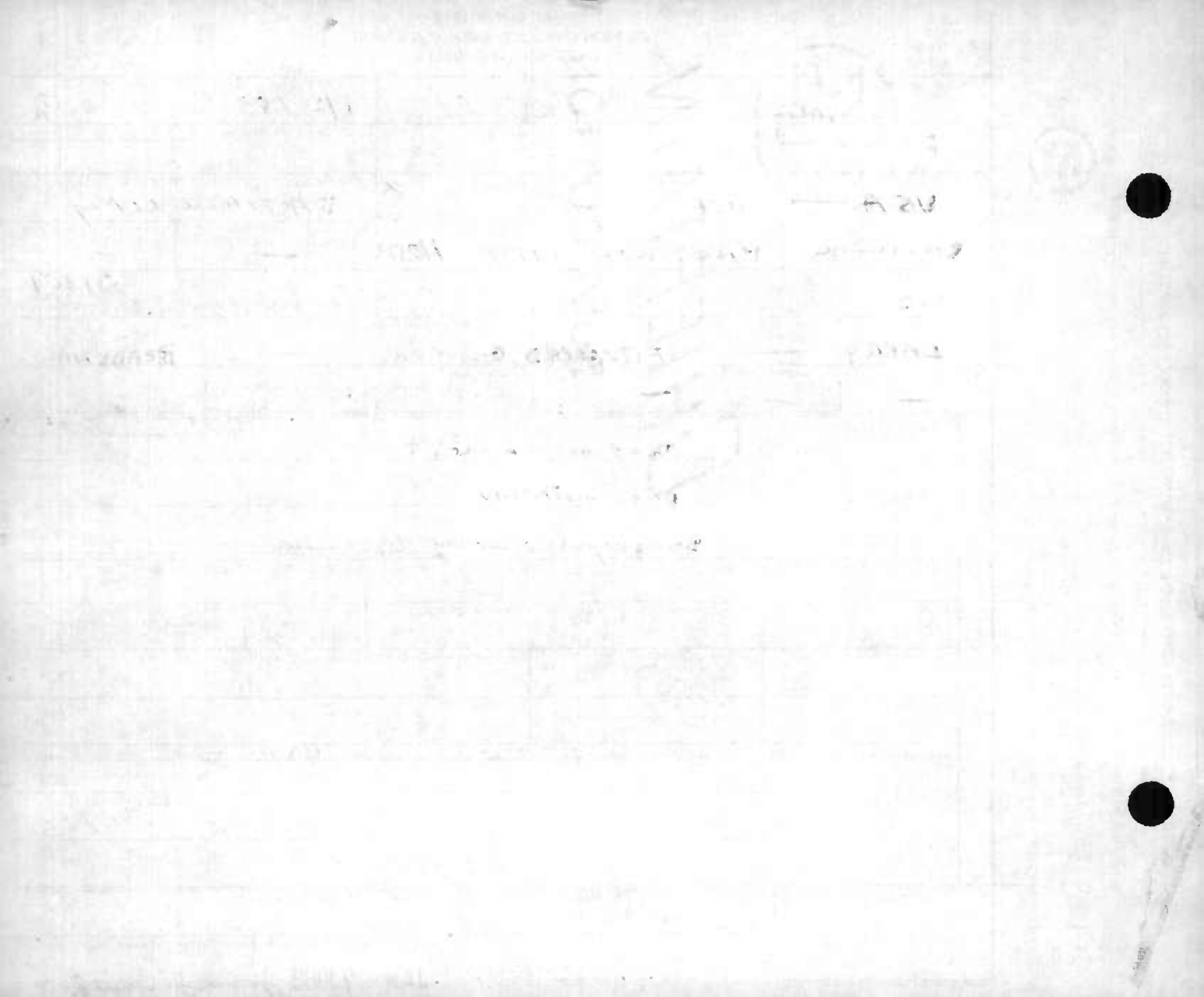
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                         |  |                                                                                                                               |  | 8 3 0 0 8 9 1                                                                                                                                            |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                       |  |                                                                                                                               |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>VALINE ——— FITZGERALD                                                                                                                                                                                                                                                                    |  |                                                                                                                               |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/2/83                                                                                                               |  |                                                                                                                         |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>W                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 6 82                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 2 MONTHS 2 DAYS HOURS MIN.                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSP |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—                                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                                                                  |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br>Wicomico                                                                                                       |  | 13c. CITY OR TOWN<br>Salisbury                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LARRY ———                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>GENEVA ——— BRADSHAW                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>—                                                                                   |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO.<br>—                                                                                                                                                                                                                                                                                                |  | 17. INFORMANT ADDRESS<br>Mr. Larry T. Fitzgerald<br>406 Woodview Sq. Apt 1, Salisbury Md.                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>7707 IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Bronchopulmonary dysplasia<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                           |  |                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7/82, 19____, to 1/2/83, 19____, that (I) (we) lost saw the deceased alive on 1/2/82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>B Straus MD                                                                                                                                                                                                                                                                                                |  | DEGREE                                                                                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br>1/2/83                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B STRAUS                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br>BCH                                                                                                           |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>1-5-1983                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Mem. Park                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Salisbury Wicomico Md.                                                       |  |
| 24. FUNERAL DIRECTOR NAME<br>Holloway Funeral Home                                                                                                                                                                                                                                                                           |  | ADDRESS<br>P.A. Salisbury, Md.                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 7 1983 John J. Carver                                                                    |  |                                                                                                                         |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or checked, any injury, or other traumatic event, the medical examiner must be notified at a hospital or funeral home.

RELEASED ON APPROVAL BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                            |                                                                                                                                        |                                                                                                                                                          |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    | REG. NO. 83 00892                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                             |  |                                            | 1. DECEASED NAME (TYPE OR PRINT) <u>Albert W. Fitzhugh III</u>                                                                         |                                                                                                                                                          |                                                            | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>11</u> YEAR <u>83</u>                                                                                                  |  |                                                                                                                                    | 2b. HOUR <u>6:44</u> <sup>AM</sup> |                                              |  |
| 3. SEX <u>male</u>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE <u>Black</u>                       |                                                                                                                                        | 5. DATE OF BIRTH MONTH <u>9</u> DAY <u>2</u> YEAR <u>68</u>                                                                                              |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY) <u>14</u> YRS                                                                                                                  |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>                                                                                        |                                    | IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |                                                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.                                                                                                 |  |                                                                                                                                    |                                    |                                              |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                                         |  |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospitals</u> |                                                                                                                                                          |                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                  |  |                                                                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |                                              |  |
| 13a. STATE <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY <u>Baltimore</u>               |                                                                                                                                        | 13c. CITY OR TOWN <u>Baltimore</u>                                                                                                                       |                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                   |  | 13e. STREET ADDRESS <u>304 N. Eutaw St. 21201</u>                                                                                  |                                    |                                              |  |
| 14. FATHER'S NAME FIRST <u>Albert</u> MIDDLE <u>W</u> LAST <u>Fitzhugh, Jr.</u>                                                                                                                                                                                                                                                                                                                                    |  |                                            |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST <u>Patricia</u> MIDDLE <u></u> LAST <u></u>                                                                               |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>                                                                                                                                                                                                                                                                                                                                        |  | (IF YES, GIVE WAR OR DATES)                |                                                                                                                                        | 16b. SOCIAL SECURITY NO. <u>214-90-3950</u>                                                                                                              |                                                            | 17. INFORMANT <u>Patricia Fitzhugh</u>                                                                                                                         |  | ADDRESS <u>304 N. Eutaw St.</u>                                                                                                    |                                    |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u><br><u>8930</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bedrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2°/3° burn to upper body + neck</u> |  |                                            |                                                                                                                                        |                                                                                                                                                          |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                                                               |  |                                            |                                                                                                                                        |                                                                                                                                                          |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    |                                              |  |
| 19a. DATE OF OPERATION <u>1/6/83</u>                                                                                                                                                                                                                                                                                                                                                                               |  |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>3° burn to upper body</u>                                                          |                                                                                                                                                          |                                                            | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  |                                            | 21b. TIME OF INJURY HOUR <u>AM</u> MONTH <u>1</u> DAY <u>4</u> YEAR <u>1983</u>                                                        |                                                                                                                                                          |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>Pt. was tied to bed and burned himself with a lighter and caught on fire</u> |  |                                                                                                                                    |                                    |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  |                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Home</u>                                                        |                                                                                                                                                          |                                                            | 21f. LOCATION STREET <u>704 N. Eutaw St</u> CITY OR TOWN <u>Balt</u> COUNTY <u>Balt</u> STATE <u>MD</u>                                                        |  |                                                                                                                                    |                                    |                                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/4</u> 19 <u>83</u> to <u>1/11</u> 19 <u>83</u> , that (1) (we) lost <u>saw the deceased alive on 1/4/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                                     |  |                                            |                                                                                                                                        |                                                                                                                                                          |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    |                                              |  |
| 22b. SIGNATURE <u>Joseph Osterling</u>                                                                                                                                                                                                                                                                                                                                                                             |  |                                            | DEGREE <u>MD</u>                                                                                                                       |                                                                                                                                                          |                                                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                     |  |                                                                                                                                    | 22c. DATE SIGNED <u>1/11/83</u>    |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph Osterling</u>                                                                                                                                                                                                                                                                                                                                                      |  |                                            | 22e. ADDRESS <u>Baltimore City Hospital</u>                                                                                            |                                                                                                                                                          |                                                            |                                                                                                                                                                |  |                                                                                                                                    |                                    |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                      |  |                                            | 23b. DATE <u>1/15/83</u>                                                                                                               |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cem</u> |                                                                                                                                                                |  | 23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u></u> STATE <u>MD.</u>                                                        |                                    |                                              |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H Inc.</u> ADDRESS <u>1101 E. North Ave.</u>                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                                                        |                                                                                                                                                          |                                                            | 25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1983</u>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Lohr</u>                                                                                     |                                    |                                              |  |

REPRODUCED ON VOLUNTARY MEDICAL DONATIONS.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            | 8 3 0 0 8 9 3                                                 |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                          |  | REG. NO.                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harry</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                        |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 7, 1988</b>                           |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            | 2b HOUR<br>M                                                  |  |  |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>White</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 28, 1900</b>                                                                                                  |                                                                                        |                                                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>                               |                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                               |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                         |                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                        |                                                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>              |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6507 Cleveland Ave</b> |                                                                        |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b> |                                                                                                 |                                                                           | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>                          |                                                                                                                            |                                                               |  |  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>City</b>                                                                                                             |                                                                        | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                        |                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                           | 13e. STREET ADDRESS<br><b>6507 Cleveland Ave. 21222</b>                         |                                                                                                                            |                                                               |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William</b> <b>Flanigan</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth</b> <b>Flanigan</b>      |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-07-5905</b>                                                           |                                                                        | 17. INFORMANT ADDRESS<br><b>Raymond A. Flanigan--Balto., MD. 21239</b>                                                                                     |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>arteriosclerotic cardiovascular disease</b><br>(c) <b>10 Yrs.</b> |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                                        |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                  |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19____, to <b>12/21/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/21/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or (we) did) (did not) view the body after death.             |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                                        |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 22b. SIGNATURE<br><b>Wilhelm Baermann M. D.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                        |                                                                                                                                                            | DEGREE<br><b>M.D.</b>                                                                  |                                                                                                 |                                                                           | 22c. DATE SIGNED                                                                |                                                                                                                            |                                                               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wilhelm Baermann M. D.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                        |                                                                                                                                                            | 22e. ADDRESS<br><b>Church Home Hospital, Baltimore, Maryland</b>                       |                                                                                                 |                                                                           |                                                                                 |                                                                                                                            |                                                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 23b. DATE<br><b>1/10/1983</b>                                          |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>parkwood Cemetery</b>                         |                                                                                                 |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto. Maryland</b> |                                                                                                                            |                                                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck Funeral Home, Inc. Dundalk, Md. 21222</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                        |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1988</b>                                    |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |                                                                                 |                                                                                                                            |                                                               |  |  |  |

BP



acute myocardial infarction  
epitaphic evidence of disease to first

12 21 57

1960

12/21/60

Handwritten signature and date: 12/21/60

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 8 9 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET E. FLEISCHER</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 26, 1983</b>                     |                                                                                                 | 2b. HOUR<br><b>10:58 PM</b>                                                                      |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>White</b>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 20</b>                                                                                                        |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |                                                                                                 |                                                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. MARYLAND HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bottler</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Calvert Distillery</b>                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1942 Deering Avenue 21230</b>                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Smith</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Vogel</b>                                                                                     |                                                                                    |                                                                                                 |                                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>217-18-2970</b>                                                                                                              |                                                                                    | 17. INFORMANT<br>ADDRESS<br><b>Elmer C. Fleischer 1942 Deering Avenue 21230</b>                 |                                                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>POSTOPERATIVE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ARTERY DISEASE</b> |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HOUR</b><br><b>36 HOURS</b><br><b>YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                                  |
| 19a. DATE OF OPERATION<br><b>1/25/83</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CORONARY ARTERY DISEASE</b>                                                                          |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                                                  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                             | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |                                                                                    |                                                                                                 |                                                                                                  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                                                                              |                                                                                    |                                                                                                 |                                                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    |                                                                                                 |                                                                                                  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> , 19 <b>83</b> , to <b>1/26</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                           |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 |                                                                                                  |
| 22b. SIGNATURE<br><b>Anthony L. Moulton</b> DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             |                                                                                    |                                                                                                 | 22c. DATE SIGNED<br><b>1/26/83</b>                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>(ANTHONY L. MOULTON)</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                             | 22e. ADDRESS<br><b>UNIV. MARYLAND HOSPITAL, BALTIMORE</b>                          |                                                                                                 |                                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>1/31/83</b>                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>                                                                                          |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b>                   |                                                                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                             | 24b. ADDRESS<br><b>21229</b>                                                       | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 28 1983</b>                                              | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Con...</b>                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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NEW YORK 17, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                          |  |                                                                                                                        |                                                                     |                                                                                                                                                          | REG. NO. 83 00895                                                                            |                                                                                   |                                                        |                                                                                                                         |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <del>B. R. END</del> BENJAMIN Fleishman                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |                                                                     |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR 1/8/83                                                      |                                                                                   |                                                        |                                                                                                                         | 2b. HOUR 11:31 P.M.                          |  |
| 3. SEX MALE                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE WHITE                                                                                                          |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR -9-17-10                                                                                                                 |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.                                           |                                                        | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                 |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                       |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD                            |                                                        |                                                                                                                         |                                              |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD Hosp |                                                                     |                                                                                                                                                          |                                                                                              | 12a. USUAL OCCUPATION (IF NOT WORKING LIFE) MERCHANT                              |                                                        | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL                                                                                |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balt 13c. CITY OR TOWN OTKESVILLE                                                                                                                                                                                                      |  |                                                                                                                        |                                                                     |                                                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   | 13e. STREET ADDRESS 7203 Chalkstone Dr APT. A-1 #21208 |                                                                                                                         |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph XXX Fleishman                                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |                                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST mollie Klavansky                                                                                              |                                                                                              |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXX No (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                        |  |                                                                                                                        |                                                                     | 16b. SOCIAL SECURITY NO. 212-09-9472                                                                                                                     |                                                                                              | 17. INFORMANT ADDRESS Rena Fleishman 7203 CHALKSTONE DR. ARTS APTS #21208         |                                                        |                                                                                                                         |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |                                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                              |                                                                                   |                                                        |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0                                                                                                                                                                                                                            |  |                                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                              |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  |                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                        |  |                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-8, 19 83, to 1-8, 19 83, that (I) (we) last saw the deceased alive on 1/8, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                                                   |  |                                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                              |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                              |  |                                                                                                                        |                                                                     |                                                                                                                                                          | 22c. DATE SIGNED 1/9/83                                                                      |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey A. Posner, MD                                                                                                                                                                                                                                                                                                   |  |                                                                                                                        |                                                                     |                                                                                                                                                          | 22e. ADDRESS Univ of MD Hosp                                                                 |                                                                                   |                                                        |                                                                                                                         |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                              |  |                                                                                                                        | 23b. DATE 1/10/83                                                   |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH CEM.                                         |                                                                                   | 23d. LOCATION BALTIMORE, MD. COUNTY STATE              |                                                                                                                         |                                              |  |
| 24. FUNERAL DIRECTOR'S NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)                                                                                                                                                                                                                                                         |  |                                                                                                                        |                                                                     |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR JAN 12 1983                                                    |                                                                                   | 25b. REGISTRAR'S SIGNATURE John J. Smith               |                                                                                                                         |                                              |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME 111)  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00896

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                |         | 2a. DATE KNOWN<br>OF DEATH ESTI- <input checked="" type="checkbox"/> MONTH DAY YEAR 7b. HOUR               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |         | FIRST                                                                                                      |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                            |  | 2a. DATE KNOWN<br>OF DEATH ESTI- <input checked="" type="checkbox"/> MONTH DAY YEAR |  | 7b. HOUR                                        |  |
| JOSEPH                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | L.                                                                                                         |  |                                                                                                                                                             |  | FOLTZER, Sr.                                                                                    |  | 1-11-83                                                                             |  | M                                               |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                         |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                                                                                                          |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                      |  | 7c. DATE<br>PRONOUNCED<br>DEAD                  |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                           | W       | 9-2-1916                                                                                                   |  | 66 YRS.                                                                                                                                                     |  |                                                                                                 |  |                                                                                     |  | 1-11-83                                         |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                                                                                     |  | MD.                                             |  |
| WASHINGTON, D.C.                                                                                                                                                                                                                                                                                                                                                                                                                            |         | U. S. A.                                                                                                   |  |                                                                                                                                                             |  | Baltimore City                                                                                  |  |                                                                                     |  |                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                |  |                                                 |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 3506 Greenmount Avenue                                                                                     |  |                                                                                                                                                             |  | MASTER PLUMBER                                                                                  |  | PLUMBING.                                                                           |  |                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                 |  | 21218                                           |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  | BALTO.                                                                                                                                                      |  |                                                                                                 |  | 3905 GREENMOUNT AVE.                                                                |  |                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| Louis FOLTZER                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  | ELIZABETH YOUNG -                                                                                                                                           |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT                                                                                   |  | ADDRESS                                                                             |  |                                                 |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                            |  | 213-01-6270                                                                                                                                                 |  | Mr. Joseph L. Foltzer, Jr. - 1001 Harford Rd.                                                   |  | Pyleville, Md. 21132                                                                |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.                                               |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                 |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |                                                                                     |  |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                              |         |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                     |  |                                                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                          |  |                                                                                                 |  | DATE<br>SIGNED 1-12-83                                                              |  |                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                            |  | ADDRESS                                                                                                                                                     |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |  | 111 Penn Street                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                     |  |                                                 |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | 1-15-83                                                                                                    |  | GARDENS OF FAITH CEM.                                                                                                                                       |  | BALTO. MD.                                                                                      |  |                                                                                     |  |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                   |  | 25b. REGISTRAR'S SIGNATURE                                                          |  |                                                 |  |
| Vante Hill - 7527 Harford Rd.                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                                                                                             |  | JAN 17 1983                                                                                     |  | James J. Canine                                                                     |  |                                                 |  |



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WASHINGTON, D.C.



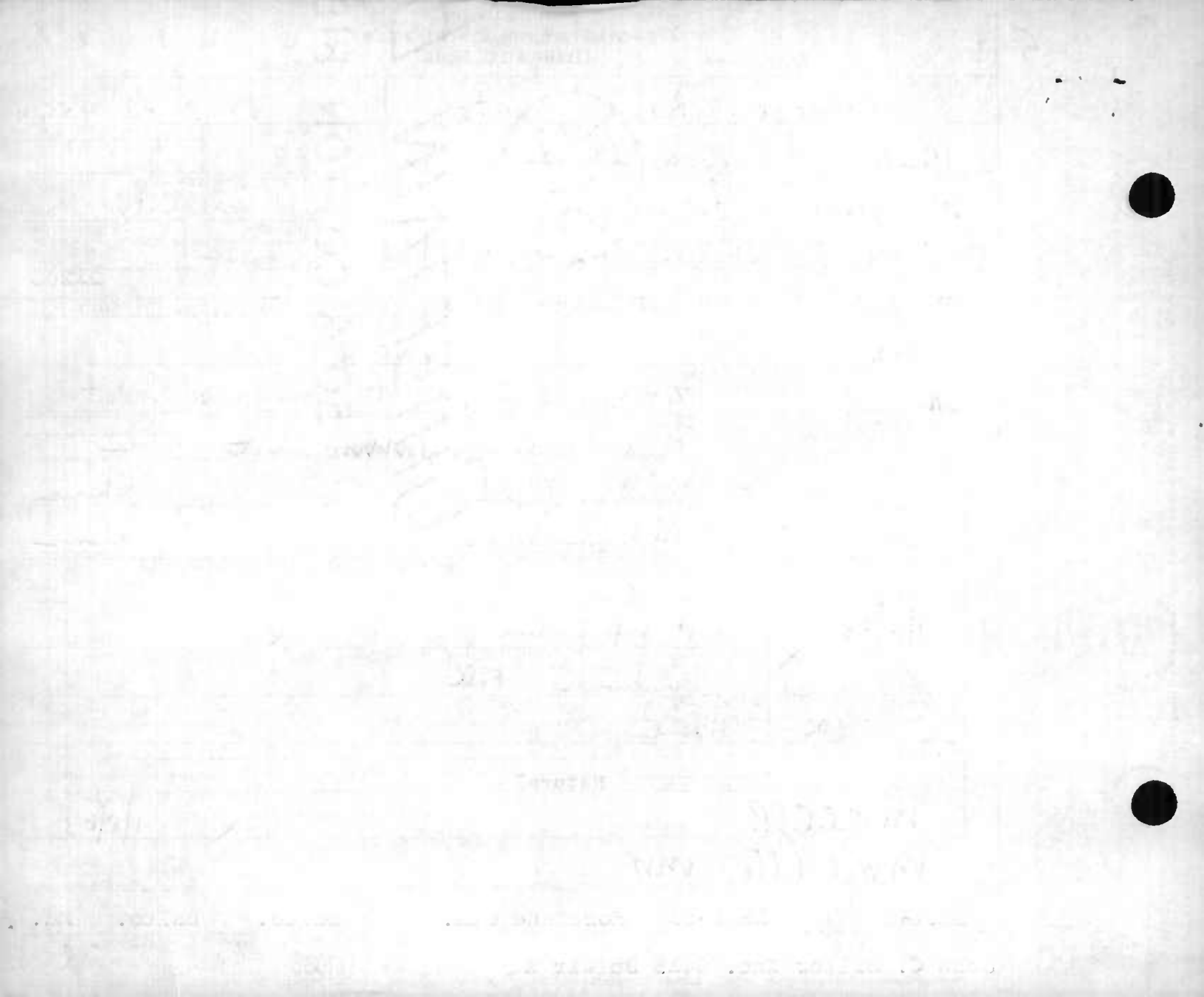
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WASHINGTON, D.C.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                        |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                        |                           | MONTH DAY YEAR                                                      |  | 2b. HOUR                                                                      |  |
| George                                                                                                                                                                                                                                                                                                                                     |  | Raymond Foot                                                                                           |  | 1                                                                                                                                                        |                           | 8                                                                   |  | 45:58 PM                                                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |                           | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                                            |  |
| Male                                                                                                                                                                                                                                                                                                                                       |  | Caucasian                                                                                              |  | MONTH DAY YEAR                                                                                                                                           |                           | 84                                                                  |  | MONTHS DAYS                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. IF UNDER 24 HRS.                                                          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                   |  | United States                                                                                          |  |                                                                                                                                                          |                           | Baltimore City                                                      |  | HOURS MIN.                                                                    |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                           | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | 13. STREET ADDRESS                                                            |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                  |  | Wyman Park Health System                                                                               |  | Seafarer                                                                                                                                                 |                           |                                                                     |  | 21206                                                                         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |                           | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                                           |  |
| Maryland                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | Baltimore                                                                                                                                                |                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5316 Philippi Avenue                                                          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |                           | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT ADDRESS                                                         |  |
| UNK                                                                                                                                                                                                                                                                                                                                        |  | UNK                                                                                                    |  |                                                                                                                                                          |                           | 714034029                                                           |  | Inpatient Admission Sheet                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic disorder</u>                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                           |  | 2762                                                                                                                                                     |                           | shows                                                               |  | shows                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                           |                                                                     |  |                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 1/6/83                                                                                                                                                                                                                                                                                                                                     |  | Left hip fracture                                                                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | Fall                                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>unknown</u>                                       |  | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                           | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE                      |  | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                               |  | Home                                                                                                   |  |                                                                                                                                                          |                           |                                                                     |  |                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u> |  |                                                                                                        |  |                                                                                                                                                          |                           |                                                                     |  |                                                                               |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                         |                           | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                               |  | 22e. ADDRESS                                                                  |  |
| M. R. Little                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 1/8/83                                                                                                                                                   |                           | M. R. Little M.D.                                                   |  |                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                           | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  | 23e. DATE REC'D. BY REGISTRAR                                                 |  |
| Burial                                                                                                                                                                                                                                                                                                                                     |  | 1-12-83                                                                                                |  | Moreland Cem.                                                                                                                                            |                           | Balto. Balto. Md.                                                   |  | JAN 10 1983                                                                   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          | 25. REGISTRAR'S SIGNATURE |                                                                     |  |                                                                               |  |
| John C. Miller Inc. 6415 Belair Rd/                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          | J. C. Miller              |                                                                     |  |                                                                               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                        |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          | 8 3 0 0 8 9 8                      |                                                                                |                                         |                                                                |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                          | 2a. DATE OF DEATH                  |                                                                                |                                         |                                                                |                                              |
| MARIE HELEN FORD                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                          | JAN 31 83 11:20 AM                 |                                                                                |                                         |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                |                                                                     | 5. DATE OF BIRTH                                                                                                                                         |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                         | 7b. HOUR                                                       |                                              |
| FEMALE                                                                                                                                                                                                                                                                                                              |  | WHITE                                                                                                  |                                                                     | 9 MONTH 4 DAY 95                                                                                                                                         |                                    | 87 YRS.                                                                        |                                         | 11:20 AM                                                       |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                         |                                                                |                                              |
| Maryland                                                                                                                                                                                                                                                                                                            |  | USA                                                                                                    |                                                                     |                                                                                                                                                          |                                    | Baltimore City, MD.                                                            |                                         |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     |                                                                                                                                                          |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                                         | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                           |  | Keswick Home                                                                                           |                                                                     |                                                                                                                                                          |                                    | Homemaker                                                                      |                                         | Own Home                                                       |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                            |                                                                     | 13c. CITY OR TOWN                                                                                                                                        |                                    | 13d. INSIDE CITY LIMITS?                                                       |                                         | 13e. STREET ADDRESS                                            |                                              |
| Maryland                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     | Baltimore                                                                                                                                                |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                         | 106 W. University Pkwy. 21210                                  |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                    |                                                                                |                                         |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     | FIRST MIDDLE LAST                                                                                                                                        |                                    |                                                                                |                                         |                                                                |                                              |
| William C. Fraser                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     | Marie Ripplemyer                                                                                                                                         |                                    |                                                                                |                                         |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                    | 17. INFORMANT ADDRESS                                                          |                                         |                                                                |                                              |
| No                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     | 217 12 8100                                                                                                                                              |                                    | Campbell F. Ford, PA                                                           |                                         |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4860                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                | 48 hrs                                       |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| Arteriosclerotic Cardiovascular Disease                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                    | 20a. AUTOPSY?                                                                  |                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                         | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                  |  |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                                                                                                                                                          |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |                                         |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        | P.M. 19                                                             |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                              |  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                         |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| 22a. I certify that (I) this hospital attended the deceased from 28 JAN 19 81, to 31 JAN 19 83, that (I) (we) lost saw the deceased alive on 31 JAN 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | DEGREE                                                                         |                                         | 22c. DATE SIGNED                                               |                                              |
| Aubrey D. Richardson M.D.                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    |                                                                                |                                         | 31 JAN 1982                                                    |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | 22e. ADDRESS                                                                   |                                         |                                                                |                                              |
| Aubrey D. Richardson, M. D.                                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | Keswick Home, Balto., MD                                                       |                                         |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                           |  |                                                                                                        | 23b. DATE                                                           |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                | 23d. LOCATION CITY OR TOWN COUNTY STATE |                                                                |                                              |
| Burial                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 2/3/83                                                              |                                                                                                                                                          | Lorraine Park                      |                                                                                | Balto., MD                              |                                                                |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | 25a. DATE REC'D. BY REGISTRAR                                                  |                                         | 25b. REGISTRAR'S SIGNATURE                                     |                                              |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                    | FEB 1 1983                                                                     |                                         | John J. Canine                                                 |                                              |

BP



PAID  
WHITE  
U.S.  
Postage  
10c  
100 W. University Ave.  
Chicago, Ill.  
1911

Handwritten notes and stamps at the bottom of the page, including a large '10c' stamp and various illegible markings.

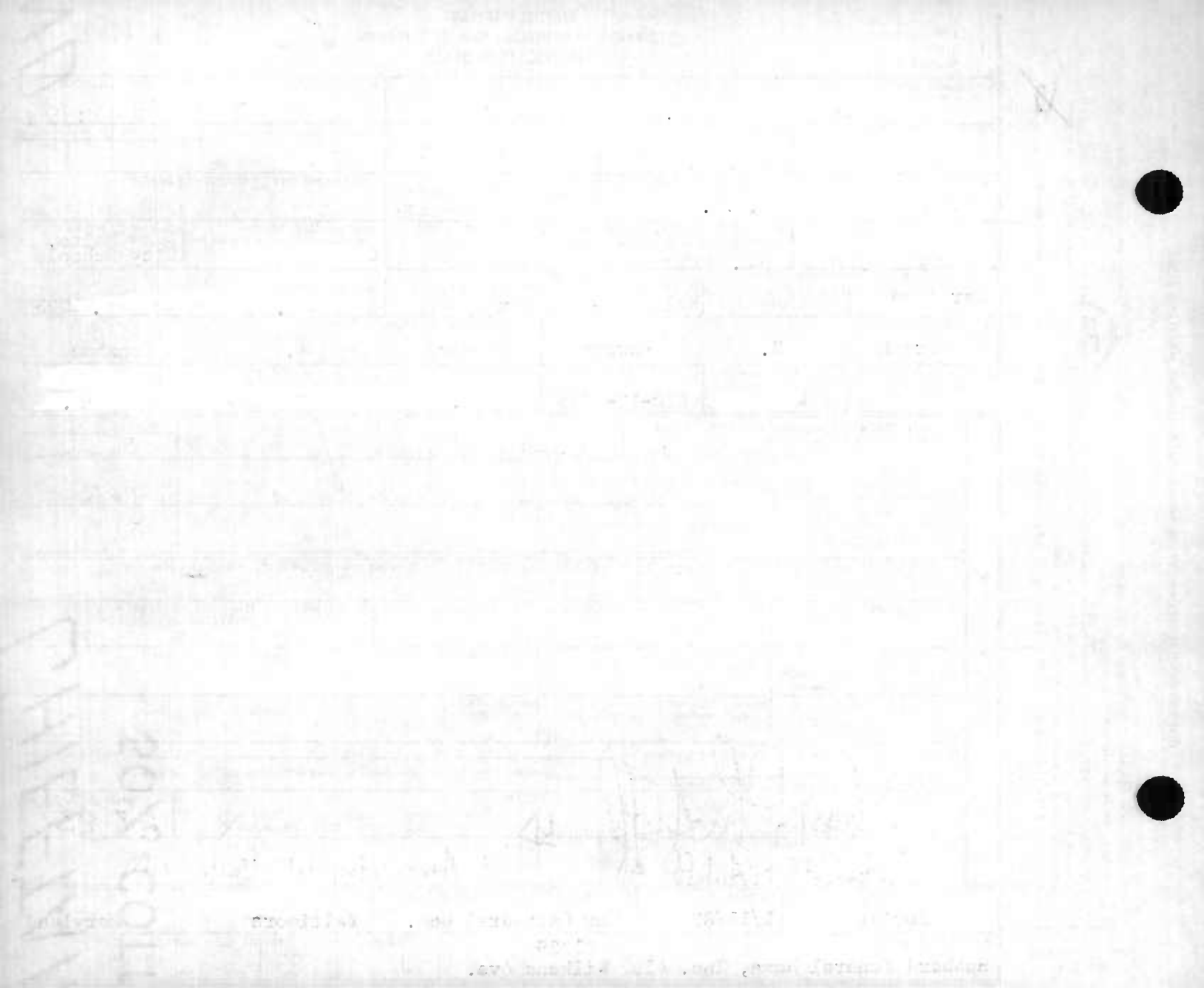
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                        |  | 8 3 0 0 8 9 9                                                                                                                                               |  |                                                                                                                                                 |                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                        |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                                 |                                                          |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FRANK E. FORNEY                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 8 83                                                                                                                  |  |                                                                                                                                                 |                                                          |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                        |  | 4. RACE<br>White                                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 10 15                                                                                                   |                                                          |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                     |  | 7c. IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                                          |  | 7d. HOUR<br>1:59 AM                                                                                                                             |                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                      |                                                          |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Custodian                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto City Schools                                                                                         |                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13c. CITY OR TOWN<br>Baltimore                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>312 S. Stricker Street 21223                                                                                             |                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank B. Forney                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Donahue                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II                                               |  |                                                                                                                                                 |                                                          |
| 16b. SOCIAL SECURITY NO.<br>220-12-4945                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 17. INFORMANT ADDRESS<br>Mary K. Ridgley 1223 Tugwell Drive 21228                                                      |  |                                                                                                                                                             |  |                                                                                                                                                 |                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe peripheral vascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>years</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>36 hours</u> |  |                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hours |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                                 |                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                      |                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on above, (I) (we) did (I) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                 |                                                          |
| 22b. SIGNATURE<br><u>Gregory A. McAniff MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22c. ADDRESS<br>St Agnes Hospital Balto MD                                                                             |  | 22d. DATE SIGNED<br>1-8-83                                                                                                                                  |  | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>1/11/83                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                                                |                                                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canine</u>                                                                                             |                                                          |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 0 0

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carrie B. Foster                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 29 83 |                                                                                                                                                             |                                                                                      | 2b. HOUR<br>M                                                                                   |                                                                                                                            |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>Black                                                                                                                          |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 15 01                                                                                                               |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                                      |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>911 N. Patterson Park Avenue |                                                |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY                                                                                                                               |                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>N/A                                                                                      |                                                | 13e. STREET ADDRESS<br>911 N. Patterson Park Ave.                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-24-1274                                                                    |                                                | 17. INFORMANT<br>ADDRESS<br>Bessie Mitchell 911 N. Patterson Park                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HYPERNATREMIA</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>INANITION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>MULTIPLE CEREBROVASCULAR ACCIDENTS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mos.</u><br><u>4 mos.</u><br><u>3 years</u> |  |                                                                                                                                           |                                                |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |
| 22a. I certify that (I) this hospital attended the deceased from <u>3/15/82</u> , 19 <u>82</u> , to <u>12/23</u> , 19 <u>82</u> , that (I) (we) last saw the deceased <u>12/22</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                            |  |                                                                                                                                           |                                                |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><u>Kevin R. Fox</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                                                    |                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                                      | 22c. DATE SIGNED<br>1/29/83                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KEVIN R. FOX                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                                                                                    |                                                |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>1/4/83                                                                                                                       |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.                                                                                                     |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Socia Ad                                |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |                                                | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983                                                                                                                 |                                                                                      |                                                                                                 |                                                                                                                            |

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NO. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edgar B Fraling</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>01-18-83</b>                                                                                                         |  |                                                                                                                         |                                                                             |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE <b>black</b>                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>7 14 1900</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.                                                                          |                                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. City</b> MD.                                                              |                                                                             |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Md. Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RAILROAD Retired</b>                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                                                             |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS <b>111 W. Centre St. 21201</b>                                                                      |                                                                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>SIMON FRALING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine COOK</b>                                                                                         |  |                                                                                                                         |                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>207-07-4675</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 17. INFORMANT ADDRESS <b>MARIE HAWKINS 111 W Centre St. Apt. 1709</b>                                                                                    |  |                                                                                                                         |                                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4960</b><br>(b) <b>pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>severe chronic obstructive pulm. disease yrs.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>oliguria</b> |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>mins.</b><br><b>days</b> |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |                                                                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                                                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18/83</b> to <b>1/18/83</b> , that (I) (we) lost saw the deceased alive on <b>1/18/83</b> , and (that (I) (we) did not view the body after death) (our) opinion death occurred on the date and hour and from the causes stated above.                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         |                                                                             |
| 22b. SIGNATURE <b>R. Robie-Suh</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/18/83</b>                                                                                         |                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robie-Suh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 22e. ADDRESS <b>Univ. of Md. Hosp.</b>                                                                                                                   |  |                                                                                                                         |                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE <b>1-22-83</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALvary Church Aberdeen</b>                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>MD</b>                                                                       |                                                                             |
| 24. FUNERAL DIRECTOR NAME <b>BROWN-Thompson F.H.</b> ADDRESS <b>1913 W. Bldg St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  | 25. REGISTRAR'S SIGNATURE <b>John J. Lauer</b>                                                                                                           |  |                                                                                                                         |                                                                             |

BP



CL-10-2-10

*[Faint, mostly illegible handwritten text on lined paper]*

100 YRS NATL CALORY CHARTERED ABERDEEN

100-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00902

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>BEULAH</b> MIDDLE <b>S.</b> LAST <b>FRANCIS</b><br><b>FRANKS</b> <b>BEUKAN</b> |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01-07-83</b>                                                                                            |  | 2b. HOUR<br><b>3:30pm</b>                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 1 10</b>                                                             |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA</b>                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.<br><b>72</b> YRS. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home &amp; Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                               |  |
| 13a. STATE<br><b>MD</b>                                                                                                        |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Savage</b>                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha</b>                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>                    |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                         |  | 17. INFORMANT ADDRESS<br><b>Edward Francis 7433 Oakland Mills Rd.</b>                                           |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ~~CARDIORESPIRATORY~~ **CARDIORESPIRATORY ARREST**

**2500**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **DIABETES MELLITUS, CONGESTIVE HEART FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                               |  |                                                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                  |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-04-</b> 19 <b>83</b> , to <b>01-07-</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>01-07-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) |  |                                                                                               |  |                                                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/7/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. WALKER IMPAGLIATELLI M.D.</b>                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b> |  |                                                                                                                                 |  |                                                                                                                            |  |

|                                                                                    |  |                             |  |                                                              |  |                                                                   |  |
|------------------------------------------------------------------------------------|--|-----------------------------|--|--------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                      |  | 23b. DATE<br><b>1/12/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  |                             |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 10 1983</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                  |  |

RECEIVED  
JANUARY 20 1944  
U.S. DEPT. OF AGRICULTURE

1943

1943

2000

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 0 9 0 3

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                                                                |                                                                                                                                                             |                                   |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUIS FRANK SR.</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 16, 1983</b> |                                                                                                                                                             | 2b. HOUR<br>MIN.<br><b>5:45 M</b> |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                          |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 1895</b>                                                                                                      |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>87</b>                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2905 FALLSTAFF ROAD APT 18 21209</b> |                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COURT REPORTER</b>                                                                   |                                   | 12b. SUPPLEMENTAL INDUSTRY<br><b>SUPREME BENCH BALTO. CITY</b>                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?<br><b>MARYLAND</b> <b>BALTIMORE</b> <b>YES XX NO</b>                                                                                                                                                            |  |                                                                                                                                                      |                                                                |                                                                                                                                                             |                                   |                                                                                                                            |  |
| 13e. STREET ADDRESS<br><b>2905 FALLSTAFF ROAD APT. 18</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                      |                                                                | 13f. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                   |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB FRANK</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>REBECCA SACHS</b>                                                                                       |                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>WWI ARMY</b>                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>217-32-7561</b>                                                                                                       |                                                                | 17. INFORMANT<br>ADDRESS<br><b>RUTH N. FRANK 2905 FALLSTAFF ROAD APT. 18</b>                                                                                |                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Lt. Dis, decomp.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis</b> |  |                                                                                                                                                      |                                                                |                                                                                                                                                             |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min</b><br><b>15 yrs</b><br><b>25 yrs</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic bronchitis &amp; Emphysema</b>                                                                                                                                                                                                     |  |                                                                                                                                                      |                                                                |                                                                                                                                                             |                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                   |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/83</b> to <b>1/16/83</b> , that (I) (we) lost saw the deceased alive on <b>1/10/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                      |  |                                                                                                                                                      |                                                                |                                                                                                                                                             |                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Jonas Cohen</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                      |                                                                | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                   | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>jonas cohen</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |                                                                | 22e. ADDRESS<br><b>6702 PARK HEIGHTS AVE.</b>                                                                                                               |                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>1-18-83</b>                                                                                                                          |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                                                                                               |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN, BALTO, MD.</b>                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |  |



RECEIVED  
FEB 12 1961



UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These pages remove carbonpapers. Pages 1 and 2 should be filed with 272 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-4676.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Teresa Dolores Frank</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>1/8/83 9:30 AM</b>                                                                             |                                                                                   |                                                                                                                         |                                                  |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Caucasian</b>                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 3, 1897</b>                                                                                                     |                                                                                                                                            | 6. AGE IN YEARS LAST BIRTHDAY<br><b>85</b>                                        |                                                                                                                         |                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                |                                                                                                                         |                                                  |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Glen Burnie</b>                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                               |                                                                                   | 13e. STREET ADDRESS<br><b>253 Woodhill Dr. 21061</b>                                                                    |                                                  |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Bernard McConville</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Delia Murphy</b>                                                                          |                                                                                   |                                                                                                                         |                                                  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                 |  | 17. INFORMANT ADDRESS<br><b>Margaret D. Frank Same as #13</b>                                                                                               |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>5140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Acute pulmonary Edema</b><br>(c) _____<br>DUE TO: OR AS A CONSEQUENCE OF<br>DUE TO: OR AS A CONSEQUENCE OF |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                               |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |                                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1/8/83</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8/83</b> to <b>1/8/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (to) (d) did not view the body after death.                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                                                            |                                                                                   |                                                                                                                         |                                                  |                                              |
| 22b. SIGNATURE <b>Moges Gebremariam</b> DEGREE                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  |                                                                                                                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                   |                                                                                                                         | 22c. DATE SIGNED<br><b>1/8/83</b>                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Moges Gebremariam</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                             | 22e. ADDRESS<br><b>Lutheran Hospital</b>                                                                                                   |                                                                                   |                                                                                                                         |                                                  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>1/11/83</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>                                                                                               |                                                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>        |                                                                                                                         |                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>MacNabb Funeral Home, Catonsville, MD</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>                                                                                        |                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>                                                                     |                                                  |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EVELYN FRANKLIN                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 30, 1983                |                                                                                                                                                             |                                                                 | 2b. HOUR<br>9:50A.M.                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                  |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>COL                                                                                                                |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 25, 1921                                                                                                         |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                                                                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                           |                                                                                                 |                                                                                                                            |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSP |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                                                 |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                    |                                                                                                 |                                                                                                                            |                                                  |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTIMORE                                  |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>4124 MOUNTWOOD ROAD 21229 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE CLARK                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETHEL GRAFFIN         |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217 22 8814 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>MRS EDITH SMITH 4124 MOUNTWOOD ROAD |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON WITH MAXX METASTASES<br>DUE TO, OR AS A CONSEQUENCE OF TO BRAIN, LUNGS, AND LIVER.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>URINARY TRACT INFECTION AND BACTEREMIA; ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE                                                                                                                                                                                           |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                                                                            |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                  |  |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                                                                            |                                                  |  |
| 22a. I certify that (1) this hospital attended the deceased from JANUARY 24, 19 83, to JANUARY 30, 19 83, that (1) we last saw the deceased alive on JANUARY 30, 19 83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.                                                                                       |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                  |  |
| 22b. SIGNATURE<br>T. PAGLIANAU, MD.                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>JANUARY 30, 1983                                                                                       |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. PAGLIANAU, MD.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231                                                              |                                                                                                 |                                                                                                                            |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 23b. DATE<br>1-4-83                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDER HILL CEM            |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BROOKLYN A.A. Co MD                               |                                                                                                                            |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOSEPH L. RUSS 2222 W. NORTH AVE                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1983                                                                                                          |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Lohr                                                                                 |                                                  |  |

MEDICAL CERTIFICATION



100% COTTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 0 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                   |  |                                                                                                                        |                                               |                                                                                                                                                             |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILBERT FRANKLIN                                                           |  |                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 7 83 |                                                                                                                                                             |  | 2b. HOUR<br>11 58 A M                                                                           |  |
| 3. SEX<br>Male                                                                                                    |  | 4. RACE<br>Black                                                                                                       |                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 13 37                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kinston, N.Car.                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                    |                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE NAME IN FULL AND STREET ADDRESS)<br>3209 Belmont Ave. |                                               |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maryland Cup Co.            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |  | 13b. COUNTY<br>Balto.                                                                                                  |                                               | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Franklin                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy Holmes                                                          |                                               | 16. SOCIAL SECURITY NO.<br>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes                          |  |                                                                                                 |  |
| 17. INFORMANT<br>Betty Franklin 3209 Belmont Ave.                                                                 |  |                                                                                                                        |                                               | 18. ADDRESS                                                                                                                                                 |  |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1850 METASTATIC ADENOCARCINOMA OF PROSTATE<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 mos. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  
PORTAL HYPERTENSION 2° CIRRHOSIS. DIABETES MELLITUS

|                                                                                                                                                          |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |

22a. I certify that (I) (this hospital) attended the deceased from 6, 19 80, to 1/7, 19 83, that (I) (we) lost  
saw the deceased alive on 12/8, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did) (did not) view the body after death.

|                                                            |  |                                                                                                                                            |  |                                                                                            |  |
|------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| 22b. SIGNATURE<br>GLEN E JOHNSON MD                        |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED<br>1/7/83                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GLEN E JOHNSON MD |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22e. ADDRESS<br>SUITE 202 PINE HEIGHTS MED CENTRAL<br>1001 PINE HEIGHTS AVE BALTI MD 21229 |  |

|                                                                                          |  |                      |  |                                                          |  |                                                                |  |
|------------------------------------------------------------------------------------------|--|----------------------|--|----------------------------------------------------------|--|----------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                   |  | 23b. DATE<br>1/12/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Vet. Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>LEROY O. DYETT & SON F.H. 4600 LIBERTY HGTS. AVE |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983             |  |                                                                |  |
|                                                                                          |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner             |  |                                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

11-11-11

11/11

FOR THE UNIVERSITY OF KENTUCKY

20% COLLEGE

11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00907

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                   |                                                                                                                                                             |                                                                                              | 2b. HOUR                                                                          |                                                                 |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN A. FREBERT, JR.                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                | JANUARY 16, 1983                                                                                                   |                                                                                                                                                             |                                                                                              | 7:10A.M.                                                                          |                                                                 |                                                                                                                         |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>WHITE                                                                                                               |                                                                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV. 4, 1904                                                                                                             |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>78                                        |                                                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |                                                                                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |                                                                 |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |                                                                                                                    |                                                                                                                                                             |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STIFF SIL. CO.   |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>SIL. SMITH                                                                         |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br>MD. BALTO.                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 13b. CITY OR TOWN<br>PARKVILLE                                                                                     |                                                                                                                                                             | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                   | 13d. STREET ADDRESS<br>8627 1/2 QUENTIN AVE. 21234              |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN A. FREBERT, SR.                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY A. FOY                                                          |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>[blank]                                                                                |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>FAMILY RECORDS                                                      |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4439 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE; CONGESTIVE OBSTRUCTIVE PULMONARY DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARRHYTHMIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>FEMORAL POPLITEAL BYPASS GRAFT, RIGHT LEG; DIABETES MELLITUS                                                                                                                                                                                                                               |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION<br>JANUARY 5, 1983<br>JANUARY 6, 1983                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PERIPHERAL ARTERIAL INSUFFICIENCY<br>OCCLUSION OF BYPASS GRAFT |                                                                                                                                                             |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                      |  |                                                                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                     |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                   |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 22a. I certify that (I) this hospital attended the deceased from DECEMBER 30, 19 82, to JANUARY 16, 19 83, that (I) we last saw the deceased alive on JANUARY 16, 19 83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If not, please do not view the body after death.)                                                                                                     |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                                         |  |                                                                                                                                |                                                                                                                    |                                                                                                                                                             |                                                                                              | 22c. DATE SIGNED<br>1/16/83                                                       |                                                                 |                                                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER IMPAGLIATELLI, MD                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231                            |                                                                                                                                                             |                                                                                              |                                                                                   |                                                                 |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                | 23b. DATE<br>JAN. 19, 1983                                                                                         |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD LEM                                           |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD. |                                                                                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME<br>EVANS                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                | 24. FUNERAL DIRECTOR ADDRESS<br>Funeral Chapel 8800 Harbor                                                         |                                                                                                                                                             |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                      |                                                                 | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                               |                                              |

MEDICAL CERTIFICATION



UNIT 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and of course, page 3 should be filled in.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| REG. NO. 8300908                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jacob French</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 9, 1983</b>                                                                                        |                                                                                                 | 2b. HOUR<br><b>9:50 A</b>                             |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Black</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 20, 1928</b>                                                                                                 |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54 Years</b> YRS.                                         |                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                       |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown Laborer</b>      |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                                                                   |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                       | 13e. STREET ADDRESS<br><b>1104 Argyle Avenue</b>                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>294-28-3622</b>                                                                 |  | 17. INFORMANT<br>ADDRESS<br><b>Medical Records Dept. 827 Linden Ave.<br/>Maryland General Hospital</b>                                                      |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung with Bone and Brain Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                         |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 14, 1982</b> , to <b>January 9, 1983</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 9, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                       |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Jim-Jer Hwu, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>1-9-83</b>                     |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jim-Jer Hwu M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                                                                                             | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                 |                                                                                                 |                                                       |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>1/12/83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                       |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |  |                                                                                                                                                             | ADDRESS<br><b>Balto., Md.</b>                                                                                                                        |                                                                                                 | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 17 1983</b> |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                  |                                                                                                 |                                                       |                                                                                                                            |  |



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Block

100-2-300

100-2-300

Unknown

100-2-300

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NOTICE  
COLLIER

JAN 27 1983  
JAN 27 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |  | REG. NO. 83 00910                                                                                                                                           |  |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jonathan FULLWOOD</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 17, 1983</b>                                                                                              |  | 2b. HOUR<br><b>3:15<sup>a</sup> M</b>                                                                                      |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 11 11</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Iris Fullwood</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lorriane Roberson</b>                                                                                   |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>220-14-3903</b>                                                                                                |  | 17. INFORMANT<br>ADDRESS<br><b>Hannah Fullwood 910 Newington Ave.</b>                                                                                       |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Cardiopulmonary arrest</b><br>IMMEDIATE CAUSE (a)<br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>Diabetes Mellitus</b><br>years |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2:40am January 17, 1983</b> to <b>January 17, 1983 3:15a</b> (we) lost<br>saw the deceased alive on <b>January 17, 1983 3:15a</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                          |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Joseph E. Piszczek, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1-17-83</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph E. Piszczek, M.D.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>1/23/83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lynchburg S.C.</b>                                                        |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                                                                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Ganiel</b>                                                                                                         |  |                                                                                                                            |                                              |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                             |  | 8 3 0 0 9 1 1                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                             |  | REG. NO.                                                                                        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank A. Furst</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH <b>I</b> DAY <b>24</b> YEAR <b>93</b> HOUR <b>5:00</b> AM            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>White</b>                    | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>6</b> YEAR <b>99</b>                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. Gen. Hosp.</b>                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine, Maintenance</b> |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |                                                                                                                                                             |  | 13b. COUNTY<br><b>---</b>                                                                       |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                 |  |
| 13e. STREET ADDRESS<br><b>1216 Battery Ave. Balto. Md. 21230</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |                                                                                                                                                             |  |                                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Furst</b> LAST <b>Furst</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>                                                                  |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-01-9598</b>                                                                               |  | 17. INFORMANT<br>ADDRESS <b>21162</b><br><b>Madeline Croke, 5213 Barent St. Whitmarsh, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Gall bladder</b><br>5741<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>peritonitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>cholecystitis &amp; cholelithiasis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>COPD CHF</b> |                                            |                                                                                                                                                             |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            |                                                                                                                                                             |  |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                      |                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/93</b> to <b>1/24/93</b> , that (I) (we) last saw the deceased alive on <b>1/24/93</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  |
| 22b. SIGNATURE<br><b>J. L. Soler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                            | DEGREE                                                                                                                                                      |  | 22c. DATE SIGNED<br><b>I/24/93</b>                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. L. Soler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | 22e. ADDRESS<br><b>3001 S HANOVER ST BALH. MD.</b>                                                                                                          |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            | 23b. DATE<br><b>Jan. 27, 1983</b>                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Maryland</b> STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                             |  |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</b> ADDRESS <b>21230</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>                                             |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ALEXANDER

Gadson

(GASKIN)

3. SEX

male

4. RACE

Black

5. DATE OF BIRTH

9-20-22

6. AGE (IN YEARS  
LAST BIRTHDAY)

58 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

HOURS MIN.

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED

MONTH DAY YEAR

1 22 19 83

2b. HOUR

M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

S. Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

611 N. Pulaski St.

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

611 N. Pulaski St. 21215

14. FATHER'S NAME

Nathaniel

MIDDLE

Gadson

LAST

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

237-28-3927

17. INFORMANT

ADDRESS

Joe Gasque 2221 N. Fulton St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY.

3030 IMMEDIATE CAUSE (a) Alcoholism

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion  
death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE  
SIGNED 1-22-83EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

1/27/83

23c. NAME OF CEMETERY OR CREMATORY

Md. Veteran Cemetery

23d. LOCATION  
CITY OR TOWN

Crownsville

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR  
NAME

ADDRESS

Wm. C. March F/H Inc. 1101 E. North Avenue

25a. DATE REC'D. BY REGISTRAR

JAN 24 1983

25b. REGISTRAR'S SIGNATURE

J. C. J. Carver

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.



REGISTERED

MAILED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP. 16

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 1 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lottie L. Gaffney</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 3, 1983</b>          |                                                                                                                                                             | 2b. HOUR<br><b>4:00P<sub>M</sub></b>                                                 |                                                                   |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Caucasian</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 22 1915</b>                                                                                                   |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                 |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 13b. COUNTY<br><b>Pr. Geo.</b>                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Hyattsville</b>                                              |                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ezra Wicker</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Venie Williams</b> |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>                                                                                                          |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Charles T. Gaffney (above address)</b><br>(Husband)                                                                          |                                                                                      |                                                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Brain Swelling</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Metastatic Carcinoma, Left</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Temporoparietal from Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiac Arrest (in operating room)</b>      |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                      |                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>October, 1982</b><br><b>October, 1982</b>                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Anemia</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>January 3, 1983</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Metastatic Carcinoma Left Temporoparietal from Lung</b>                                |                                                                        |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                   |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 15</b> , 19 <b>82</b> , to <b>January 3</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 3</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not see the body after death. |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>William H. Mosberg, Jr.</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><b>1-4-83</b>                                 |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William H. Mosberg, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                        | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>                                                                                                        |                                                                                      |                                                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>1/6/1983</b>                                                                                                                  |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>                                                                                          |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pr. Geo. Md.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nalley's F.H. Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>Mt. Rainier, Md.</b>                                                                                                            |                                                                        | 25. DATE REGISTERED BY REGISTRAR<br><b>JAN 12 1983</b><br><i>John J. Gaffney</i>                                                                            |                                                                                      |                                                                   |                                                                                                                            |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 1 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CLIFTON GAINES                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-27-83 |                                                                                                                                                             |                                                                                      | 2b. HOUR<br>6:54 PM                                                                             |                                                                                                                            |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>B                                                                                                                        |                                             | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 1 06                                                                                                                   |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                                      |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |                                             |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                            |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                         |                                             | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 13e. STREET ADDRESS<br>2531 W. BALTO ST.<br>945-3199                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>TURNER GAINES                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>HENRIETTA MILLS                                                                                               |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-05-7624                                                              |                                             | 17. INFORMANT ADDRESS<br>Ruth Gaines 2531 W. Baltimore street                                                                                               |                                                                                      |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>1519<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) ABDOMINAL SEPSIS S/P GASTRECTOMY FOR GASTRIC CA 14 DAYS |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 DAYS                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br>S/P GASTRECTOMY & ESOPHAGOGASTROSTOMY; GASTRIC CA, RENAL FAILURE                                                                                                                                                                                                 |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION<br>1/7/83                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GASTRIC CARCINOMA                                                               |                                             |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |
| 22a. I certify that (1) this hospital attended the deceased from 12/26, 1983, to 1/27, 1983, the (1) (we) last saw the deceased alive on 1/27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.                                                                                          |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>Guillermo W. Arnaud                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      | 22c. DATE SIGNED<br>1/27/83                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GUILLERMO W. ARNAUD                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      | 22e. ADDRESS<br>UNIVERSITY HOSPITAL<br>22 S. GREENIE ST.                                        |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>2/2/83                                                                                                                 |                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk.                                                                                                  |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.                                       |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |                                             | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 31 1983                                                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Gass                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |

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FOR COTTON

Jan 31 1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                             | REG. NO.                                                    |                                                                                      |  |                                                                                                                            |  |                                                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES PRESTON GAINES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 15, 1983</b> |                                                                                      |  |                                                                                                                            |  | 2b. HOUR<br><b>12:35 PM</b>                                                                                                          |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>BLACK</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 8 1913</b>                                                                                                      |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |                                                                                                                            |  |                                                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                             |                                                             |                                                                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONSTRUCTION ENG.</b>                                  |  |                                                                                                                                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY CONSOLIDATED<br><b>ENGINEERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13a. STATE<br><b>MARYLAND</b>                                                                                                               |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                             |                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>1010 N. BENTALOU ST</b>                                                                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CHARLES H. GAINES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SALLIE BUTLER</b>                                                                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                             |                                                             | 16b. SOCIAL SECURITY NO.<br><b>218-05-9244</b>                                       |  | 17. INFORMANT ADDRESS<br><b>JOSEPH D. ALEXANDER 8303 FORRESTER BLVD. SPRINGFIELD, VA.</b>                                  |  |                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>4 yrs</b> |  |                                                                                                                                             |  |                                                                                                                                                             |                                                             |                                                                                      |  |                                                                                                                            |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                             |                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1115</b> 19 <b>83</b><br>P.M. 19                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |                                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                                                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> , 19 <b>82</b> , to <b>1/15</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                                                                             |                                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                                                      |  |
| 22b. SIGNATURE<br><b>William Sigmund</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  | DEGREE<br><b>WILLIAM SIGMUND</b>                                                                                                                            |                                                             |                                                                                      |  | 22c. DATE SIGNED<br><b>1/15/83</b>                                                                                         |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM SIGMUND</b>                                                                      |  |
| 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  |                                                                                                                                                             |                                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>1-20-83</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PH</b>                                                                                            |                                                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MD.</b>              |  |                                                                                                                            |  |                                                                                                                                      |  |
| 24. FUNERAL DIRECTOR NAME<br><b>NUTTER FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | ADDRESS<br><b>3035 W. NORTH AVE</b>                                                                                                                         |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |                                                                                                                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  |                                                                                                                                                             | REG. NO.                                                              |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Melinda Gaither</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 28, 1983</b>           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 | 2b. HOUR<br><b>12:45aM</b> |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 12 1910</b>                                                                                                      |                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                    |                                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                                                                 |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                             |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>                                                                       |                                                                                                 |                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  |                                                                                                                                                             | 13b. COUNTY<br><b>---</b>                                             |                                                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                      |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Gaither</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Williams</b> |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>                                                                         |  | 17. INFORMANT<br><b>Mrs. Becky Estes</b>                                                                                                                    |                                                                       | ADDRESS<br><b>19 Druid Hill Ave. Baltimore, Maryland</b>                             |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Carcinoma of the Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Colon Carcinoma</b> |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Colon Carcinoma</b>                                                                                                                                                                                                                              |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |                                                                                                                                                             |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 22a. I certify that (this hospital) attended the deceased from <b>January 27, 1983</b> , to <b>January 28, 1983</b> , that (we) last saw the deceased on <b>January 28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                               |  |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 22b. SIGNATURE<br><b>Gwendolyn Bollings</b> MD                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  |                                                                                                                                                             | DEGREE<br><b>MD</b>                                                   |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>1/28/83</b>                                                              |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gwendolyn Bollings, M.D.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |  |                                                                                                                                                             | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                  |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>1-31-83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Browns Chapel Cemetery Dayton</b>                                                                                  |                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Maryland</b>                 |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Haight Funeral Home</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                   |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |
| ADDRESS<br><b>Sykesville, Md.</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |  |                                                                                                                                                             | REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                        |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                                 |                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                      |  | 83 00917                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARION T. GAJEWSKI</b>                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                      |  | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 1 83</b>                                                                                                        |  | 2b. HOUR<br><b>330 P M</b>                                                                                                 |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 25 1899</b>                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                                                                                            |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>                                                                                                                                                                                                                                                                                                           |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                                                                                                                                                                                                                                                                                                                            |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO CITY HOSP.</b> |  | 12r. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BARBER</b>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                              |                     | 13b. COUNTY<br><b>BALTO</b>                                                                                                          |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13r. STREET ADDRESS<br><b>3128 ELLIOTT ST 21224</b>                                                                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN GAJEWSKI</b>                                                                                                                                                                                                                                                                                                       |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                    |                     | 16b. SOCIAL SECURITY NO.<br><b>216-32-9905</b>                                                                                       |  | 17. INFORMANT<br>ADDRESS<br><b>MICHAEL GAJEWSKI</b>                                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>SAME</b>                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                     |                                                                                                                                      |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                 |                     |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 P.M. 19</b>                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/82</b> 19 <b>83</b> to <b>1/1</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |                     |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Charles W. H. [Signature]</b>                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                      |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>1/1/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles W. H. [Signature]</b>                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                      |  | 22e. ADDRESS<br><b>BALTIMORE CITY MD</b>                                                                                                                    |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                           |                     | 23b. DATE<br><b>1/5/83</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                      |  | 25b. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>                                                                                                          |  | 25a. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                                                         |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |                                                      |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELizabeth B. Gallacher</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 5 83</b> |                                                                                                                                                             |                                                                                         | 2b. HOUR<br><b>10<sup>53</sup> P.M.</b>                                                                                                    |                                                                                                                            |                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Cau.</b>                                                                                                            |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 17 28</b>                                                                                                        |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                                                                          |                                                                                                                            |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                     |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                                                             |                                                                                                                            |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>City Hospital</b> |                                                      |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Switch Board</b> |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Apts.</b>                                                                      |                                   |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>-</b>                                                                                                           |                                                      | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                                                                            |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hampton Beecher</b>                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann M. Aker</b>                                                               |                                                      | 13e. STREET ADDRESS<br><b>1218 Armstead Way 21205</b>                                                                                                       |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-7471</b>                                                                                    |                                                      | 17. INFORMANT<br>ADDRESS<br><b>Ann M. Beecher 1218 Armstead Way</b>                                                                                         |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                                                   |                                                      |                                                                                                                                                             |                                                                                         |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                |  |                                                                                                                                   |                                                      |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |                                                      |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                 |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/5/83</b> , 19____, to <b>1/5/83</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>1/5/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If I (we) did (did not) view the body after death.)            |  |                                                                                                                                   |                                                      |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 22b. SIGNATURE<br><b>Lapard</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |                                                      | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                         | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>1/5/83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |                                                      | 22e. ADDRESS                                                                                                                                                |                                                                                         |                                                                                                                                            |                                                                                                                            |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>1-8-83</b>                                                                                                        |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Balto. Md.</b>                                                                     |                                                                                                                            |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc. 6415 Belair Rd.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>                                                                                                         |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                        |                                                                                                                            |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                     |  |                                                                                                                            |  | 8 3 0 0 9 1 9                                                                                                                                            |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                           |  |                                                                                                                            |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> ALICE <sup>MIDDLE</sup> L <sup>LAST</sup> GAMBLE                                                                                                                                                                                                               |  |                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 11 08 83 2b. HOUR 1230 P.M.                                                                                           |  |                                                                                                                         |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                                    |  | 4. RACE Black                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 03 84                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Baltimore 13d. CITY OR TOWN Baltimore 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                        |  |                                                                                                                            |  | 13f. STREET ADDRESS 312 N CAREY ST 21223                                                                                                                 |  |                                                                                                                         |  |
| 14. FATHER'S NAME <sup>FIRST</sup> Charles <sup>MIDDLE</sup> D. <sup>LAST</sup> Weems                                                                                                                                                                                                                            |  |                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Bessie <sup>MIDDLE</sup> E. <sup>LAST</sup> Smothers                                                           |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO                                                                                                                                                                                                                                            |  |                                                                                                                            |  | 16b. SOCIAL SECURITY NO. 220-20-9913                                                                                                                     |  | 17. INFORMANT Bessie E. Weems 11 W. 20th St.                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiopulmonary Arrest                                                                                                                                                            |  |                                                                                                                            |  | DUE TO, OR AS A CONSEQUENCE OF (b) Massive Myocardial Infarction                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12:30 pm 1/8/83                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                   |  |                                                                                                                            |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                       |  | 6pm (1/7/83) 18 1/2 hrs                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension                                                                                                                                                                    |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 30 P.M. 1 8 83                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Cardiopulmonary Arrest                                                    |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Hospital                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22 S. Greene St Balto Balto MD                                                                            |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 AM 1/8/83 to 12:30 pm 1/8/83, that (I) (we) last saw the deceased alive on 1/8/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                            |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE Steven G. Gevas MD                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  | DEGREE MD                                                                                                                                                |  | 22c. DATE SIGNED 1/8/83                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven G. GEVAS                                                                                                                                                                                                                                                            |  |                                                                                                                            |  | 22e. ADDRESS 22 S. Greene St Balto MD                                                                                                                    |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                 |  | 23b. DATE 1/13/83                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.                                                                                                      |  | 23d. LOCATION COUNTY MD STATE                                                                                           |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                    |  |                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR JAN 10 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE John J. Conner                                                                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

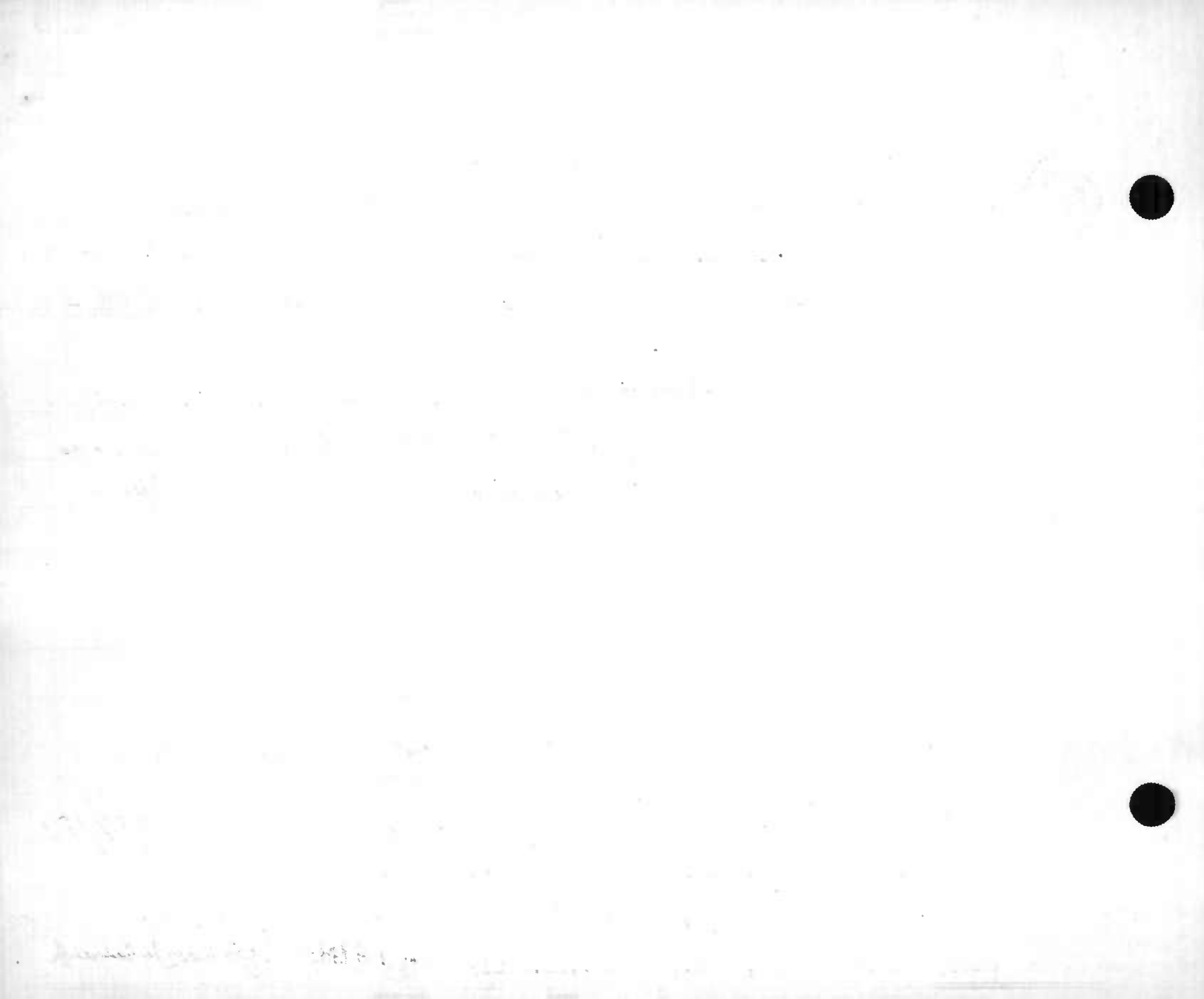
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 2 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                     |                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AMY EVANS GANGE</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 5, 1983</b>       |                                                                                                                                                                   |  | 2b. HOUR<br>P.<br><b>6:00</b>                                                                             |  |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                         |                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 24, 1884</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.                                                         |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tonypandy, Wales</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                         |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>817 St. Paul Street - 21202</b> |                                                                     |                                                                                                                                                                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Concert and Opera Singer-Rtrd.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>---</b>                                                                                                                       |                                                                     | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>817 St. Paul St. Apt# 612 - 21202</b>                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Evans</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leah Davies</b> |                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-8360</b>                                                                   |                                                                     | 17. INFORMANT<br>ADDRESS<br><b>Samuel J. Aaron - 416 N. Charles St. - 21202</b>                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS H/D</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b> |  |                                                                                                                                                 |                                                                     |                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                                     |                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                                     |                                                                                                                                                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                    |  |                                                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                 |  |                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 26</b> 19 <b>69</b> , to <b>7/6</b> 19 <b>78</b> , that (I) (we) last saw the deceased alive on <b>7/6</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                     |  |                                                                                                                                                 |                                                                     |                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>F. Mark Dugan</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |                                                                     | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                           |  | 22c. DATE SIGNED<br><b>1/7/83</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F. Mark Dugan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                                     | 22e. ADDRESS<br><b>15 E. Biddle Street - 21202</b>                                                                                                                |  |                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>Jan. 10, 1983</b>                                                                                                               |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematorium</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland-21202</b>                            |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry Sander &amp; Sons, Inc.,</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |                                                                     | ADDRESS<br><b>Balto., Md. 21213</b>                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 8 3 0 0 9 2 1                                                                                                                                               |  |                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | CERTIFICATE OF DEATH                                                                                                                                        |  |                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                           |  |                                                                |  |
| EMMA K. GARNER                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | JAN. 29 1983 6:11 P.M.                                                                                                                                      |  |                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                              |  |
| FEMALE                                                                                                                                                                                                                                                                                                              |  | BLACK                                                                                                  |  | 08 25 98                                                                                                                                                    |  | 84 YRS.                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| VA.                                                                                                                                                                                                                                                                                                                 |  | USA                                                                                                    |  |                                                                                                                                                             |  | Baltimore City MD.                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                           |  | NORTH CHARLES GEN. HOSP                                                                                |  |                                                                                                                                                             |  |                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                              |  |
| MD                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  | BALTO                                                          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS                                          |  |
| NO                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | 48-14-5113                                                                                                                                                  |  | Richard P. Garner 301 McMechen St #1005                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| 4860 IMMEDIATE CAUSE (a) Sepsis                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| (b) pneumonia and urinary tract infection                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| (c)                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| Anemia Dehydration                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                     |  | P.M. 19                                                                                                |  |                                                                                                                                                             |  |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION                                                                                                                                               |  |                                                                |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                   |  |                                                                                                        |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                            |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-27, 19 82, to 1-29, 19 83, that (I) (we) last saw the deceased alive on 1-29, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | DEGREE                                                                                                                                                      |  | 22c. DATE SIGNED                                               |  |
| C. VERGARA-SOARES                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | M.D.                                                                                                                                                        |  | 1-29-83                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                                |  |                                                                |  |
| C. VERGARA-SOARES                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | N. CHARLES GEN. HOSP. BALT. MD. 21218                                                                                                                       |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                  |  |
| BURIAL                                                                                                                                                                                                                                                                                                              |  | 2/2/83                                                                                                 |  | Mt. Calvary Cem.                                                                                                                                            |  | BROOKLYN, N.Y.                                                 |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Chatman-Harris 1701 McCullough St                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | FEB 8 1983                                                                                                                                                  |  | John J. Conner                                                 |  |

page 3 death



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NEW YORK 17, N.Y.

FEB 8 1953

Franklin D. Roosevelt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 2 2

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY (Nmi) GASPICH</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 25 83</b>                                              |                                                                                                                                                             |                                                          | 2b. HOUR <b>11:50 PM</b>                                                                                          |                                                             |                                                                                                                         |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE <b>White</b>                                                                                                                   |                                                                                              | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 / 30 / 1894</b>                                                                                                        |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS                                                                     |                                                             | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                             |                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                                    |                                                             |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b> |                                                                                              |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>                                   |                                                             | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>                                                                                                                                                                             |  |                                                                                                                                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                             | 13e. STREET ADDRESS <b>7102 Martell Ave 21222</b>        |                                                                                                                   |                                                             |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN Stanko</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen UNKNOWN</b>                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO <b>213.74.8895</b><br><b>213.04.09120</b>                                                                      |                                                                                              | 17. INFORMANT <b>Albert Gaspich</b>                                                                                                                         |                                                          | ADDRESS <b>7313 Holabird Ave. 21222</b>                                                                           |                                                             |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><b>2059 IMMEDIATE CAUSE (a) myelomonocytic leukemia</b>                                                                                                                                                                                       |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 mos</b>                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                 |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                             |                                                                                                                                                             |                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                            |                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  |                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 19</b>                                    |                                                                                                                                                             |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                    |                                                             |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                  |  |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |                                                                                                                                                             |                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                    |                                                             |                                                                                                                         |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>12/78</b> , 19 <b>82</b> to <b>1/25</b> , 19 <b>83</b> , that (I/we) lost saw the deceased alive on <b>1/22</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
| 22b. SIGNATURE <b>D. Proops, MD</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        | DEGREE <b>HOUSE STAFF</b>                                                                    |                                                                                                                                                             |                                                          | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                             | 22c. DATE SIGNED <b>1/25/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. PROOPS, MD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        | 22e. ADDRESS <b>BCH 4440 Eastern Ave Balto MD</b>                                            |                                                                                                                                                             |                                                          |                                                                                                                   |                                                             |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 23b. DATE <b>1/28/1983</b>                                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b> |                                                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b> |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc. Dundalk MD.</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                                              |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1983</b>         |                                                                                                                   | 25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>            |                                                                                                                         |  |

MEDICAL CERTIFICATION



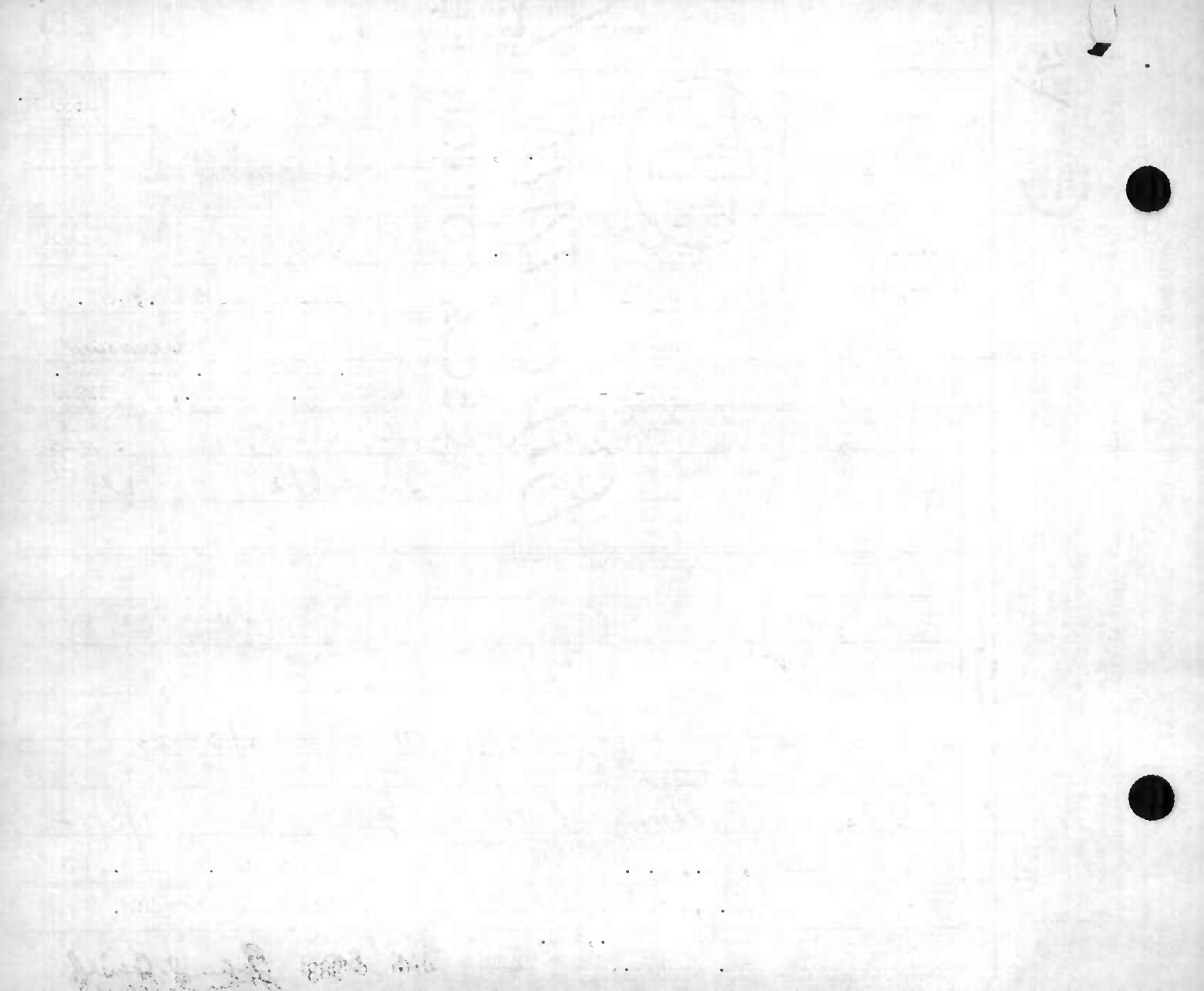
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                             |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             | REG. NO.                                                   |                                                                                                 |                                                     |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) JACK ROBERT GAZER                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR JANUARY 2, 1983        |                                                                                                 |                                                     | 2b. HOUR<br>9:39 A.M.                                                                                                      |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br>WHITE                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR SEPT. 6, 1911                                                                                                            |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                                      |                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ENGLAND                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                     |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2802 DAMASCUS CT., APT. A |  |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN                    |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>AUTOMOBILE                                                                            |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                     | 13e. STREET ADDRESS<br>2802 DAMASCUS CT., APT. A                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST HYMAN GAZER                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST MARY UNKNOWN |                                                                                                 |                                                     |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>167-12-3193A                                                                |  | 17. INFORMANT<br>MRS. JEANETTE T. GAZER APT. A<br>2802 DAMASCUS CT. BALTO., MD 21209                                                                        |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma liver</u><br>1552<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma colon probable</u><br>DO TO, OR AS A CONSEQUENCE OF<br>(c) <u>1 1/2 x 2</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mths</u> |  |                                                                                                                                        |  |                                                                                                                                                             |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  |                                                                                                                                                             |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><u>none</u>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> 19 <u>71</u> , to <u>1/2</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1/2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                             |                                                            |                                                                                                 |                                                     |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Maurice Feldman</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  |                                                                                                                                                             | DEGREE<br>PA                                               |                                                                                                 |                                                     | 22c. DATE SIGNED<br>1/3/82                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAURICE FELDMAN, JR., M.D.                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  |                                                                                                                                                             | 22e. ADDRESS<br>6610 CROSS COUNTRY BLVD. BALTO., MD        |                                                                                                 |                                                     |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>JAN. 4, 1983                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE                                                                                                           |                                                            | 23d. LOCATION<br>PIKESVILLE BALTO. MD                                                           |                                                     |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u> |                                                                                                                            |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 2 4

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH C. GEIGER, SR.</b>                                                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 31 83</b>                           |                                                                                                 | 2b. HOUR<br><b>7:10 P<sub>M</sub></b>                                                                                         |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>White</b>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 28, 1895</b>                                                                                             |                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |
| 13a. STATE<br><b>Alabama</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Warrior</b>                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>104 Marion Street 35180</b>                                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wolfgang Geiger</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Appolonia Rimmell</b>                                                                                   |                                                                                  |                                                                                                 |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW 1</b>                                                                                                                                                                                                                                        |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>213-09-5023</b>                                                                                                              |                                                                                  | 17. INFORMANT ADDRESS<br><b>Joseph C. Geiger, Jr. 400 Plumtree Rd. 21014</b>                    |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4280 IMMEDIATE CAUSE (a) Congestive Heart Failure</b>                                                                                                                                                                                      |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)                                                                                                                                                                                                                                                                                                                      |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                                                               |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                      |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>INVEST WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                            |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>83</b> , to <b>1/31</b> , 19 <b>83</b> , that (we) lost<br>saw the deceased alive on <b>1/23</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death. |                                                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                                                               |
| 22b. SIGNATURE<br><b>Robert A. Miller M.D.</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                             | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                  | 22c. DATE SIGNED<br><b>1/31/83</b>                                                              |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT A. MILLER M.D.</b>                                                                                                                                                                                                                                                                                      |                                                                                                                                             | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                              |                                                                                  |                                                                                                 |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                              | 23b. DATE<br><b>2-3-1983</b>                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                                                                                                  |                                                                                  | 23d. LOCATION<br><b>Baltimore</b> COUNTY <b>Maryland</b>                                        |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>                                                                                                                                                                                                                                                                     |                                                                                                                                             | 1050 York Road<br>ADDRESS                                                                                                                                   |                                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>                                              | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                           |





9 OCT 1958

5 20 000 11 000 12 000 13 000 14 000 15 000 16 000 17 000 18 000 19 000 20 000 21 000 22 000 23 000 24 000 25 000 26 000 27 000 28 000 29 000 30 000 31 000 32 000 33 000 34 000 35 000 36 000 37 000 38 000 39 000 40 000 41 000 42 000 43 000 44 000 45 000 46 000 47 000 48 000 49 000 50 000 51 000 52 000 53 000 54 000 55 000 56 000 57 000 58 000 59 000 60 000 61 000 62 000 63 000 64 000 65 000 66 000 67 000 68 000 69 000 70 000 71 000 72 000 73 000 74 000 75 000 76 000 77 000 78 000 79 000 80 000 81 000 82 000 83 000 84 000 85 000 86 000 87 000 88 000 89 000 90 000 91 000 92 000 93 000 94 000 95 000 96 000 97 000 98 000 99 000 100 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                                 |  | 8 3 0 0 9 2 5<br>REG. NO.                                                                                                             |  |                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth Estelle Gerard                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 7, 1983                                                                                                      |  |                                                                                                 |  | 2b. HOUR<br>5 50 A M                                                                                                                  |  |                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 4, 1914                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                        |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |                                                                                                                                       |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |                               |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 13b. CITY OR TOWN<br>Calvert                                                                                                                                |  | 13c. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 13d. STREET ADDRESS<br>227 Calvert Town Road                                                                                          |  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph A. Vaeth                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara E. Rider                                                                                             |  |                                                                                                 |  | 16. ADDRESS<br>Prince Frederick, Md.                                                                                                  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-1137                                                               |  | 17. INFORMANT<br>W. Eston Gerard                                                                                                                            |  |                                                                                                 |  | 17. ADDRESS<br>227 Calvert Town Rd.                                                                                                   |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>2639 IMMEDIATE CAUSE (a) <u>Malignant</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Depression anorexia</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                                       |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET<br>76                                                                                                                               |  | CITY OR TOWN<br>Jenny                                                                           |  | COUNTY<br>83                                                                                                                          |  | STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-6-83 to 1-7-83, that (I) (we) lost <u>1-6-83</u> <u>1-7-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                     |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  | 22b. SIGNATURE<br>William Helfrich MD                                                                                                 |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Helfrich, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 22e. ADDRESS<br>5006 Roland Ave. Baltimore, Md.                                                                                                             |  |                                                                                                 |  | 22c. DATE SIGNED<br>1-7-83                                                                                                            |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>Jan. 10, 1983                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore                                                      |  | COUNTY<br>Maryland                                                                                                                    |  | STATE                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 10 1983                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                    |  |                                                                                                                                       |  |                               |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                  |  |                                                                        |  |                                                    |                                                                |                                                                                                                                                             |                        | REG. NO. 00926                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GERARD J GERMACK SR                                                                                                                                                                                                                                                                                                                                                          |  |                  |  |                                                                        |  |                                                    | 2a. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br>1-12-83 |                                                                                                                                                             | 2b. HOUR<br>am<br>1:5a |                                                                                     |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 18 1934                     |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>48 YRS.      |                                                                | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1-12-83                                                                                                       |                        | 7d. HOUR<br>am<br>1:5a                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE Md                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |  |                                                    |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        |                                                                                     |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                 |  |                                                    |                                                                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5442 Gardenwood Road                          |                        |                                                                                     |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 12b. USUAL BUSINESS OR INDUSTRY<br>B.G.E.                              |  |                                                    |                                                                | 13a. STATE<br>Maryland                                                                                                                                      |                        |                                                                                     |  |
| 13b. COUNTY<br>—                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |  | 13c. CITY OR TOWN<br>BALTIMORE                                         |  |                                                    |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                        |                                                                                     |  |
| 13e. STREET ADDRESS<br>21206 5442 GARDENWOOD RD                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES J. GERMACK             |  |                                                    |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HARRIETTA M. MORAN                                                                                         |                        |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>815-30-3665 |  |                                                    |                                                                | 17. INFORMANT<br>ADDRESS<br>MRS JACQUELINE L. GERMACK - SAME                                                                                                |                        |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular<br>disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                 |  |                  |  |                                                                        |  |                                                    |                                                                |                                                                                                                                                             |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                        |  |                  |  |                                                                        |  |                                                    |                                                                |                                                                                                                                                             |                        |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |                                                    |                                                                |                                                                                                                                                             |                        | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                                    |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                        |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  |                                                    |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                        |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |                                                                        |  |                                                    |                                                                |                                                                                                                                                             |                        |                                                                                     |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                          |  |                                                    |                                                                | DATE SIGNED<br>1-12-83                                                                                                                                      |                        |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  | ADDRESS<br>111 Penn Street                                             |  |                                                    |                                                                |                                                                                                                                                             |                        |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  | 23b. DATE<br>1-15-83                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem |                                                                |                                                                                                                                                             |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE Md                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEONARD J. RUCK INC                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  |                                                                        |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 17 1983        |                                                                |                                                                                                                                                             |                        |                                                                                     |  |
| ADDRESS<br>5305 HARTFORD                                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  |                                                                        |  | REGISTRAR'S SIGNATURE<br>John J. Connel            |                                                                |                                                                                                                                                             |                        |                                                                                     |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                          |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 3 0 0 9 2 7                                                                                                                                              |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 2a. DATE KNOWN OF DEATH                                                                                                                                  |                                              |
| Ahmed - Ghazzawi                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 1-19-83 19                                                                                                                                               |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS)                            |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   | White                                                                                                   | Jan. 1, 1926                                                                                                                                             | 57 YRS.                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH         |
| Beirut, Lebanon                                                                                                                                                                                                                                                                                                                                                                                                                        | Lebanon                                                                                                 |                                                                                                                                                          | Baltimore City                               |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              | Sheraton Hotel, Broadway & Orleans                                                                      | Steel-dealer                                                                                                                                             | Steel                                        |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. CITY OR TOWN                                                                                       | 13c. STREET ADDRESS                                                                                                                                      |                                              |
| Kuwait                                                                                                                                                                                                                                                                                                                                                                                                                                 | Kuwait                                                                                                  | P.O.Box 1958                                                                                                                                             |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME                                                                                |                                                                                                                                                          |                                              |
| Fihmi - Ghazzawi                                                                                                                                                                                                                                                                                                                                                                                                                       | Zarifa - Tobara                                                                                         |                                                                                                                                                          |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                     | 16b. SOCIAL SECURITY NO.                                                                                | 17. INFORMANT                                                                                                                                            | ADDRESS                                      |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | Eman Ghazzawi                                                                                                                                            | P.O.Box 1958/Kuwait, Arabia                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Hypertensive atherosclerotic cardiovascular disease<br>(b) disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                          |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       | 20. AUTOPSY?                                                                                                                                             |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                                                                                                         |                                                                                                                                                          |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | TITLE (SPECIFY)                                                                                                                                          | DATE SIGNED                                  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | Assistant                                                                                                                                                | 1-19-83                                      |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | ADDRESS                                                                                                                                                  |                                              |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 111 Penn Street                                                                                                                                          |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE      |
| Removal                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | Bashora                                                                                                                                                  | Mousytba, Beirut                             |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                              | ADDRESS                                                                                                 | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                   |
| Lilly & Zeller Inc.                                                                                                                                                                                                                                                                                                                                                                                                                    | Baltimore, Md. 21231                                                                                    | JAN 19 1983                                                                                                                                              | John J. Lawler                               |



THIS IS TO CERTIFY THAT

THE FOLLOWING IS A TRUE AND CORRECT COPY OF THE

P.O. BOX 1000

RECEIVED

TO

FROM

THE CHAIRMAN OF THE BOARD

DATE

1991  
JAN 10 1991  
1991



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  | 8 3 0 0 9 2 8                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  | REG. NO.                                                                                                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRACE K GIAMPAOLI</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>83</b>                                 |  | 2b. HOUR<br><b>5</b> <sup>02</sup> <sub>AM</sub>                                     |  |                                                                                                                               |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH <b>SEPT.</b> DAY <b>28</b> YEAR <b>1899</b>                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                                |  | 7. UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |  | 8. UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                                                                                 |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |                                                                                      |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital, Inc.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |  |                                                                                                                               |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>TOWSON</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>511 GOUCHER BLVD. 21204</b>                                |  |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b></b> LAST <b>PESSAGNO</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b></b> LAST <b>PESSAGNO</b>                                                                           |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-8860</b>                                                                                           |  | 17. INFORMANT<br><b>ROSE E. PESSAGNO</b>                                                                                                                    |  | ADDRESS<br><b>511 GOUCHER BLVD. 21204</b>                                                       |  |                                                                                      |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4254</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                           |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                           |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  |                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |                                                                                      |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                 |  |                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                      |  |                                                                                                                               |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>12/27</b> , 19 <b>82</b> , to <b>1/9</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Joseph Notarangelo MD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>1/9/83</b>                                                    |  |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. JOSEPH NOTARANGELO</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>Mercy Hospital</b>                                                                                                                       |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>JAN. 14, 1983</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRODGE CEM.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN <b>ELKRIDGE</b> COUNTY <b>HOWARD</b> STATE <b>MD.</b>             |  |                                                                                      |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL-WIEDEFELD HOME</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | ADDRESS<br><b>6500 YORK RD. 21212</b>                                                                                                                       |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                  |  | 25b. REGISTRAR<br><b>[Signature]</b>                                                                                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                        |  |                                                                                                                               |  |                                                                                                                                                             |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               |  |                                                                                                                                                             | 8 3 0 0 9 2 9                                                |                                                                                                 |                                                            |                                                                                                                            |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  |                                                                                                                                                             | REG. NO.                                                     |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HOWARD R GIBSON                                                                                                                                                                                                                                                                               |  |                                                                                                                               |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-28-83                  |                                                                                                 |                                                            | 2b. HOUR<br>6:30 AM                                                                                                        |                                              |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>B                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 13 40                                                                                                                  |                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.                                                      |                                                            | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                            |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL |  |                                                                                                                                                             |                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                             |  |                                                                                                                               |  |                                                                                                                                                             |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                                                   |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            | 13e. STREET ADDRESS<br>2315 HARMAN AVE<br>21230 385-0035                                                                   |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WALTER GIBSON                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARTHA CARROLL |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>214-40-9621                                                                                       |  | 17. INFORMANT ADDRESS<br>Gloria Adams 101 Markham St. LA                                                                                                    |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5860 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) EXANGUINATION - DISSEMINATED INTRAVASCULAR COAG.<br>3 DAYS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) RENAL FAILURE, HEPATIC FAILURE, SEPSIS<br>40 DAYS |  |                                                                                                                               |  |                                                                                                                                                             |                                                              |                                                                                                 |                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>BRITTLE DIABETES, CONGESTIVE HEART FAILURE, HYPERCALCEMIA, RESPIRATORY INSUFFICIENCY                                                                                                                            |  |                                                                                                                               |  |                                                                                                                                                             |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br>12/1/82                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>MITRAL VALVE INSUFFICIENCY<br>CORONARY ARTERY DISEASE                     |  |                                                                                                                                                             |                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30, 19 82, to 1/28, 19 83, tho (I) (we) last saw the deceased alive on 1/28, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |                                                                                                                               |  |                                                                                                                                                             |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>GW Arnavo                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |  | DEGREE                                                                                                                                                      |                                                              |                                                                                                 |                                                            | 22c. DATE SIGNED<br>1/28/83                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G.W. ARNAVO                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL<br>22 S. GREENE ST.                                                                                                     |                                                              |                                                                                                 |                                                            |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>2/2/83                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                                                                                       |                                                              |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                 |  |                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983                                                                                                                 |                                                              | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine                                                    |                                                            |                                                                                                                            |                                              |



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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                               |  |                                                                                                                                             |                                                                |                                                                                                                                                             |                                                                                      |                                                                             |                                   |                                                                                                               |  |                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Bertha Gies</b>                                           |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 11, 1983</b> |                                                                                                                                                             | 2b. HOUR<br><b>12:15 PM</b>                                                          |                                                                             |                                   |                                                                                                               |  |                                                          |  |
| 3. SEX<br><b>Female</b>                                                                                                       |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 9, 1894</b>                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b><br>YRS. MONTHS DAYS HOURS MIN. |                                   |                                                                                                               |  |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.           |                                   |                                                                                                               |  |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hamilton Nursing Center</b> |                                                                |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                                               |  |                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |                                                                                                                                             |                                                                | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             |                                                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET ADDRESS<br><b>2716 Strathmore Ave. 21214</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James A. Billingsley</b>                                                         |  |                                                                                                                                             |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Donna Treakle</b>                                                                                       |                                                                                      |                                                                             |                                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-2254</b>           |  |
| 17. INFORMANT<br><b>Mary E. Price</b>                                                                                         |  |                                                                                                                                             |                                                                | ADDRESS<br><b>21214 2716 Strathmore Ave.</b>                                                                                                                |                                                                                      |                                                                             |                                   |                                                                                                               |  |                                                          |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4409  
IMMEDIATE CAUSE (a) **Pneumonia, aspiration**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Severe arteriosclerosis**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **Tube feeding**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**4 days**  
**year**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/83</b> , 19 <b>83</b> , to <b>1/11/83</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/11/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Dr. Raymundo S. Magno M.D.</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  | DEGREE<br><b>M.D.</b>                                                          |  | 22c. DATE SIGNED<br><b>1/11/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  | 22e. ADDRESS                                                                   |  |                                                                                                                               |  |
| <b>Dr. Raymundo S. Magno M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  | <b>7811 Wise Ave. Baltimore, Md. 21222</b>                                     |  |                                                                                                                               |  |

|                                                                                          |  |                                 |  |                                                                   |  |                                                                         |  |
|------------------------------------------------------------------------------------------|--|---------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                         |  | 23b. DATE<br><b>Jan 12 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>               |  |                                                                         |  |
|                                                                                          |  |                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>               |  |                                                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 7 days of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                                 |  | 8 3 0 0 9 3 1<br>REG. NO.                                                 |                                   |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM V GILDARK                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 11 83                                                                                                              |  |                                                                                                 |  | 2b. HOUR<br>5 <sup>50</sup> AM                                            |                                   |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 24 18                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS                                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                            |                                   | IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |                                                                           |                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer, Manufacturing      |  |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>-----                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>809 W. Cross St. Balto. Md. 21230                  |                                   |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony ----- Goldikas                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Petronella ----- Elcsciuta                                                                                 |  |                                                                                                 |  |                                                                           |                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.2                                                                     |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Josephine R. Gildark, Same as above                                                                                        |  |                                                                                                 |  |                                                                           |                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) pneumonia<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) carcinoma of lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 days<br>7 months        |                                   |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                           |                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  |                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |                                                                           |                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                           |                                   |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6, 19 83, to 1/11, 19 83, that (I) (we) lost<br>saw the deceased alive on 1/11, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                           |                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br>Richard Nora                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |                                                                                                 |  | 22c. DATE SIGNED<br>1/11/83                                               |                                   |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD NORA                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL                                                                                                                     |  |                                                                                                 |  |                                                                           |                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  | 23b. DATE<br>Jan. 14, 1983                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cent.<br>21230                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland         |                                   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Connelley                             |                                   |                                                                                                                            |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE REPRODUCED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                 |                |                                                                                                                                |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  |                                                                                                  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------|----------------|--------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|------------------------|-------------------------------------------------------|--|----------------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                 | FIRST<br>James |                                                                                                                                |  | MIDDLE<br>Vernon                                                    |  |                                                                                                                                                             | LAST<br>Gladden Sr. |                                                  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 14 19 83                                          |  |                                                              | 2b. HOUR<br>M<br>11:09 |                                                       |  |                                              |  |  |  |  |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br>Black |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 24, 1969                                                                            |  | 6 AGE (IN YEARS)<br>LAST BIRTHDAY<br>69 YRS.                        |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               |                     | IF UNDER 24 HRS.<br>HOURS MIN.                   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 14 19 83                                         |  |                                                              | 2d. HOUR<br>M<br>a     |                                                       |  |                                              |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                 |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  |                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                     |                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2219 Tucker Lane |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>Machine Oper.                                            |  |                                                              |                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Electric |  |                                              |  |  |  |  |  |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                         |  |                 |                | 13b. COUNTY<br>Baltimore                                                                                                       |  | 13c. CITY OR TOWN<br>Baltimore                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                     | 13e. STREET ADDRESS<br>2219 Tucker Lane-Apt. A-4 |  |                                                                                                  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                       |  |                                                                                                                                                             |                     |                                                  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |                                                              |                        |                                                       |  | 17. INFORMANT ADDRESS                        |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9554 IMMEDIATE CAUSE (a) Gunshot wound of chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                             |  |                 |                |                                                                                                                                |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  |                                                                                                  |  |                                                              |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |                                              |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                                     |  |                 |                |                                                                                                                                |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  |                                                                                                  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                |                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |                                                                                                                                                             |                     |                                                  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                         |  |                 |                |                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10 PM 1 14 19 83 |  |                                                                                                                                                             |                     |                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Self inflicted  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                          |  |                 |                |                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home |  |                                                                                                                                                             |                     |                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2219 Tucker Lane, Baltimore Md.             |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 22a. I certify that I have charge of the remains described above, held on<br>death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>TITLE (SPECIFY)<br>Deputy Chief MEDICAL EXAMINER<br>DATE SIGNED 1/15/83 |  |                 |                |                                                                                                                                |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  |                                                                                                  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                 |                |                                                                                                                                |  | ADDRESS<br>111 Penn St. Balto., MD.                                 |  |                                                                                                                                                             |                     |                                                  |  |                                                                                                  |  |                                                              |                        |                                                       |  |                                              |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                |                                                                                                                                |  | 23b. DATE<br>1/19/83                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garden of Eter Hope                                                                                                   |                     |                                                  |  |                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Finksburg, Md. |                        |                                                       |  |                                              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Miller - 3035 W. North Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                 |                |                                                                                                                                |  |                                                                     |  |                                                                                                                                                             |                     |                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                                     |  |                                                              |                        |                                                       |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                 |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                      | REG. NO. 8 3 0 0 9 3 3 |                                        |                                                |                        |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------|----------------------------------------|------------------------------------------------|------------------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                            |  |  | FIRST<br>William                                                                                                                |  |                                                           | MIDDLE<br>Edwin                                                                                                                                             |                                                                                                 |                                                                          | LAST<br>Glass, 3rd.                                                                  |                        |                                        | 2a. DATE KNOWN OF DEATH                        |                        | 2b. HOUR |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 4. RACE<br>White                                                                                                                |  | 5. DATE OF BIRTH<br>2/2/1919                              |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                                      |                                                                          | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                              |                        | 2c. DATE PRONOUNCED DEAD<br>1 14 19 83 |                                                | 2d. HOUR<br>12:45 p.m. |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                          |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  |                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |                        |                                        |                                                |                        |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3559 Third Street |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Agent (sales)       |                        |                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Life Ins. |                        |          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 13b. COUNTY<br>---                                                                                                              |  | 13c. CITY OR TOWN<br>Baltimore                            |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                          | 13e. STREET ADDRESS<br>3559 Third St., 21225                                         |                        |                                        |                                                |                        |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Glass, Sr.                                                                                                                                                                                                                                                                                                                                                                |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Murphy                                                                   |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>--- 99 212-07-3538                                                  |  |                                                           | 17. INFORMANT ADDRESS<br>Shirley R. Glass Same as #13                                                                                                       |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9554 IMMEDIATE CAUSE (a) Gunshot wound of head<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |                                                                                                                                 |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                      |                        |                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                        |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                               |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          | 20. HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |                                        |                                                |                        |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                 |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10 xxx 1 14 19 83                                                            |  |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Self inflicted                                                             |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                              |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home                                                             |  |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3559 Third St. Baltimore Md.                                                                           |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . (FILE (SPECIFY) _____) HEAD ONLY                                                                                         |  |  |                                                                                                                                 |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                      |  |  | M.D. Deputy Chief, MEDICAL EXAMINER                                                                                             |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          | DATE SIGNED<br>1/15/83                                                               |                        |                                        |                                                |                        |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                |  |  | ADDRESS<br>III Penn St. Balto., MD.                                                                                             |  |                                                           |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                      |                        |                                        |                                                |                        |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                            |  |  | 23b. DATE<br>1/20/1983                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk. |                                                                                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A. A. Co., Md. |                                                                                      |                        |                                        |                                                |                        |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes                                                                                                                                                                                                                                                                                                                                                                          |  |  | ADDRESS<br>Balto., Md., 21225<br>237 E. Patapsco Ave.,                                                                          |  |                                                           | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                                                 |                                                                          | 25b. REGISTRAR'S SIGNATURE<br>JAN 19 1983 John J. Carver                             |                        |                                        |                                                |                        |          |  |

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]



[Faint, mostly illegible handwritten text and lines across the page]



RECEIVED

2-15

1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00934

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                        |                                                                                                                                     |                                                                                                                                                             |                                                                                |                                                       |                                                              |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ruth C. Glorioso                                                                |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 12 83                                |                                                       | 2b. HOUR<br>6:41 PM                                          |
| 3. SEX<br>FEMALE                                                                                                       | 4. RACE<br>WHITE                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 11 1925                                                                                                             |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.            |                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD. |                                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>BENDIX                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY<br>BALTIMORE                                                       |                                                       | 13c. CITY OR TOWN<br>BALTIMORE                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LESTER J. CONNER                                                             |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY BANKERT                  |                                                       |                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                 |                                                                                                                                     |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>216 20 7489                                        |                                                       | 17. INFORMANT<br>ADDRESS<br>JOHN M. GLORIOSO 2407 FOSTER AVE |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE

5120

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) REPEATED ANOXIC, BRADYCARDIC ARRESTS

DUE TO, OR AS A CONSEQUENCE OF

(c) SEPSIS, RESPIRATORY INSUFFICIENCY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

RESPIRATORY INSUFFICIENCY

|                                   |                                                                            |                                                                                      |                                                                                                                                       |
|-----------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br>11/9/83 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>LEFT HEMO PNEUMOTHORAX | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|-----------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                       |                                                            |                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|

|                                                                                                              |                                                                        |                                                   |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|

22a. I certify that (I) (this hospital) attended the deceased from 11/8/83, 19 83, to 11/12/83, 19 83, that (I) (we) lost saw the deceased alive on 11/12, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

|                                      |        |                                                                                                                                            |                              |
|--------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 22b. SIGNATURE<br><i>[Signature]</i> | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>11/12/83 |
|--------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|

|                                                       |                                           |
|-------------------------------------------------------|-------------------------------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Ari Jaffe | 22e. ADDRESS<br>THE JOHN HOPKINS HOSPITAL |
|-------------------------------------------------------|-------------------------------------------|

|                                                         |                         |                                                         |                                |
|---------------------------------------------------------|-------------------------|---------------------------------------------------------|--------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL               | 23b. DATE<br>11/17/1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY | 23d. LOCATION<br>BALTIMORE MD. |
| 23e. NAME OF FUNERAL DIRECTOR<br>RAYMOND H. KACZOROWSKI |                         | 23f. ADDRESS<br>2525 FLEET ST                           |                                |
| 23g. DATE REC'D. BY REGISTRAR<br>JAN 19 1983            |                         | 23h. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>        |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers 1, 2, 3, and 4, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





Items #10a-22a Film G577 3/9/83 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|--|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------|--|---------------------------------------------------------------------|--|----------------------------|--|---------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         | FIRST                        |  | MIDDLE                                                      |  | LAST                                                                                                                                                     |  | 2a. DATE KNOWN OF DEATH                                                       |  | MONTH                                |  | DAY                                                                 |  | YEAR                       |  | 2b. HOUR                                                            |  |  |  |
| NEIL E. GLOVER, JR.                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              |  |                                                             |  |                                                                                                                                                          |  | 1 3 19 83                                                                     |  |                                      |  |                                                                     |  |                            |  | 4:48                                                                |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (IN YEARS)                                           |  | IF UNDER 1 YR.                                                                                                                                           |  | IF UNDER 24 HRS.                                                              |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH                                                               |  | DAY                        |  | YEAR                                                                |  |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     | Black   | 8/21/79                      |  | 3 YRS.                                                      |  |                                                                                                                                                          |  |                                                                               |  | 1 3 19 83                            |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                    |         | 7b. CITIZEN OF WHAT COUNTRY? |  |                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | U.S.A.                       |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | Baltimore City                       |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                            |  |                                                                     |  |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  | University Hospital                                         |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                              |  | 13b. COUNTY                                                 |  |                                                                                                                                                          |  | 13c. CITY OR TOWN                                                             |  |                                      |  | 13d. INSIDE CITY LIMITS?                                            |  |                            |  | 13e. STREET ADDRESS                                                 |  |  |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              |  |                                                             |  |                                                                                                                                                          |  | Balto.                                                                        |  |                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            |  | 725 George St Apt (17)                                              |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |  |                                                             |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                      |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |  |                                                             |  |                                                                                                                                                          |  | FIRST MIDDLE LAST                                                             |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| Neil Glover                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |  |                                                             |  |                                                                                                                                                          |  | Mary E. White                                                                 |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                      |  |                                      |  | 17. INFORMANT ADDRESS                                               |  |                            |  |                                                                     |  |  |  |
| no                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  | Mary E. White 725 George St.                                        |  |                            |  |                                                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| IMMEDIATE CAUSE (a) Seizure Disorder                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 7803                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  | 20. AUTOPSY?                                                        |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |         |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  | P.M. 19                                                     |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |         |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                                                                                                                                          |  | 21f. LOCATION                                                                 |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                             |  |                                                                                                                                                          |  | CITY OR TOWN COUNTY STATE                                                     |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  |                                      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | TITLE (SPECIFY)                      |  |                                                                     |  | DATE SIGNED                |  |                                                                     |  |  |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | M.D. Assistant                       |  |                                                                     |  | MEDICAL EXAMINER 1-4-83    |  |                                                                     |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | ADDRESS                              |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | 111 Penn St., Balto., Md. 21201      |  |                                                                     |  |                            |  |                                                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  | 23b. DATE                                                   |  |                                                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |                                      |  | 23d. LOCATION                                                       |  |                            |  |                                                                     |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |  | 1/7/83                                                      |  |                                                                                                                                                          |  | Mt. Auburn Cem                                                                |  |                                      |  | Balto. Md.                                                          |  |                            |  |                                                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | 25a. DATE REC'D. BY REGISTRAR        |  |                                                                     |  | 25b. REGISTRAR'S SIGNATURE |  |                                                                     |  |  |  |
| Chas A. Rice FSPA 1300 Eutawpl                                                                                                                                                                                                                                                                                                                                                                                                           |         |                              |  |                                                             |  |                                                                                                                                                          |  |                                                                               |  | JAN 11 1983                          |  |                                                                     |  | John J. Carriel            |  |                                                                     |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 1. RETAIN PAGE 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00936

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RAY GOLDBERG</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-4-83</b>                                                                                                     |                                                                                                                                                              |                                                                   | 2b. HOUR<br><b>5:40 AM</b>                                                                                 |                                                                        |                                                                                                                           |                                              |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                |                                                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-15-90</b>                                                                                                         |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                                          |                                                                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                        |                                              |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                      |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                                   |                                                                                                                                                          | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                         |                                                                        |                                                                                                                           |                                              |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                    |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALT</b> |                                                                                                                                                          |                                                                                                                                                              |                                                                   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                        |                                                                        | 15. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                        |                                              |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>MARYLAND</b> 16b. COUNTY <b>BALTIMORE</b> 16c. CITY OR TOWN <b>BALTIMORE</b> 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                           |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              | 17. STREET ADDRESS<br><b>6942 REISTERSTOWN RD. 21215</b>          |                                                                                                            |                                                                        |                                                                                                                           |                                              |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB HALPER</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LEAH UNKNOWN</b>                                                                                     |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           |                                              |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 21. SOCIAL SECURITY NO.<br><b>215-32-7076D</b>                                                                                                           |                                                                                                                                                              |                                                                   | 22. INFORMANT<br><b>MR. SAMUEL W. GOLDBERG</b><br>ADDRESS<br><b>6511 COPPER RIDGE DR., APT. 201 #21209</b> |                                                                        |                                                                                                                           |                                              |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADENIO-CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                           |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           |                                              |
| 24. DATE OF OPERATION<br><b>11-26-82</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GASTRIC OUTLET OBSTRUCTION</b>                                                                     |                                                                                                                                                              |                                                                   | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                        | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  |                                                                                                                                            | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                         |                                                                                                                                                              |                                                                   | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                              |                                                                        |                                                                                                                           |                                              |
| 31. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                    |                                                                                                                                                              |                                                                   | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                           |                                                                        |                                                                                                                           |                                              |
| 34. I certify that (I) (this hospital) attended the deceased from <b>11-12-82</b> to <b>1-4-83</b> , that (I) (we) lost saw the deceased alive on <b>1-4-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                       |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           |                                              |
| 35. SIGNATURE<br><b>Charles Schwartz</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            | 36. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                                              |                                                                   | 37. DATE SIGNED<br><b>1-4-83</b>                                                                           |                                                                        |                                                                                                                           |                                              |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES SCHWARTZ, MD</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            | 39. ADDRESS<br><b>SINAI HOSPITAL OF BALT.</b>                                                                                                            |                                                                                                                                                              |                                                                   |                                                                                                            |                                                                        |                                                                                                                           |                                              |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            | 41. DATE<br><b>JAN 5, 1983</b>                                                                                                                           |                                                                                                                                                              | 42. NAME OF CEMETERY OR CREMATORY<br><b>RIGA KURLANDER VEREIN</b> |                                                                                                            | 43. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b> |                                                                                                                           |                                              |
| 44. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                            |                                                                                                                                                          |                                                                                                                                                              | 45. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>                 |                                                                                                            | 46. REGISTRAR'S SIGNATURE<br><b>James J. Canine</b>                    |                                                                                                                           |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| Box 100         | Box 100 |
| NEW YORK, N.Y.  |         |

Mr. J. Edgar Hoover

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RE: JAMES EARL RAY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 3 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                              |  |                                                                                                                                    |                                                                   |                                                                                                                                                             |  |                                                                                   |  |
|--------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Daniel G. Goldman</b> |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>20</b> YEAR <b>83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>6:15 A</b> M                                                       |  |
| 3. SEX<br><b>MALE</b>                                        |  | 4. RACE<br><b>WHITE</b>                                                                                                            |                                                                   | 5. DATE OF BIRTH<br>MAR. 6, 1908                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>MARYLAND</b>                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAILER</b> |  |
|                                                              |  |                                                                                                                                    |                                                                   |                                                                                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SUN PAPERS</b>                            |  |

|                                                                                                                 |  |  |  |                                                                                         |  |                                                                                     |  |                                                                                                 |  |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b> |  |  |  | 13b. COUNTY                                                                             |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3608 CLARKS LA. #21215</b> |  |
| 14. FATHER'S NAME<br><b>JOSEPH GOLDMAN</b>                                                                      |  |  |  |                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br><b>REBECCA COHEN</b>                                    |  |                                                                                                 |  |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                              |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII-NAVY 213-03-2637</b> |  | 17. INFORMANT <b>MRS. MIRIAM GOLDMAN</b><br><b>3608 CLARKS LA. BALTO., MD 21215</b> |  |                                                                                                 |  |                                                      |  |

|                                                                                                                                                                                                                                                                                                                                                            |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br><b>4/100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rein Farction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b> <b>Arteriosclerotic</b> <b>M.I.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> , 19 <b>83</b> , to <b>1/20</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Paul Schwartz M.D.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/20/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL Schwartz M.D.</b>                                                                                                                                                                                                                                                                                                       |  |                                                                        |  | 22e. ADDRESS<br><b>SINAI Hospital Belvedere &amp; Greenspring 21215</b>                                                                              |  |                                                                                                                            |  |

|                                                                                                                             |  |                                   |  |                                                           |  |                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|-----------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                                  |  | 23b. DATE<br><b>JAN. 21, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 3 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Sallie Goodman</i>                                                                                                                                                                                                                                                                   |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>01 17 83</i>                 |                                                                                                                                                             |                                                                                | 2b. HOUR<br><i>01 15 PM</i>                                                                                                                |                                                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 15 1893</i>                                                                                                      |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS                                                                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                                                         |                                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                               |  |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nathan Cook</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>            |                                                                                                                                                             |                                                                                | 13e. STREET ADDRESS<br><b>1111 W. Cross Street 21230</b>                                                                                   |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-26-9121</b>                                                                |                                                                        | 17. INFORMANT ADDRESS<br><b>Bessie Anderson 1111 W. Cross Street</b>                                                                                        |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i></b>                                                                                                                                                  |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                      |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Robert T. Schreiber</i>                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | DEGREE<br><i>MD</i>                                                    |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><i>01/17/83</i>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert T. Schreiber</i>                                                                                                                                                                                                                                                         |  |                                                                                                                                              | 22e. ADDRESS<br><i>Baltimore City Hospitals, Balto Md</i>              |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                              | 23b. DATE<br><b>1/21/83</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Pk.</b>                 |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                            |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                             |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                     |  |                                                                                                                              |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |                                                                     |                                                                                                                                                             | REG. NO. E0560609                                                                                                                                    |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELLANORA GOODWIN                                                                                                                                                                                                                                                |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>01 26 83                                                                                                         |                                                                                      |                                                                          | 2b. HOUR<br>1732 M                                                                                                         |                                                                                                 |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE                                                                                                             |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 07 1896                                                                                                               |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                           |                                                                          | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                          |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                                                                     |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER               |                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT                                                                            |                                                                                                 |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 13b. COUNTY<br>---                                                                                                                                   |                                                                                      | 13c. CITY OR TOWN<br>BALTIMORE                                           |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>PATRICK BREEN                                                                                                                                                                                                                                                                     |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELLA SPURRIER                                                                                          |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                      |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>213-34-6623                                                                                                              |                                                                                      | 17. INFORMANT ADDRESS<br>RAYMOND H. LEONARD, JR. 2518 JAMES STREET 21230 |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Cardiorespiratory arrest.<br>DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. LIFE<br>DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure. 5 years.                           |  |                                                                                                                              |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                       |  |                                                                                                                              |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                          |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  |                                                                                                                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                                                                          |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 27, 19 78, to JAN 18, 19 83, that (I) (we) last saw the deceased alive on JAN 18, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                              |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br>Alejandro Mejia MD                                                                                                                                                                                                                                                                                     |  |                                                                                                                              |                                                                     |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>1/26/83                                              |                                                                                                                            |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alejandro Mejia Md                                                                                                                                                                                                                                                              |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br>1900 Sulphur Spring Rd 21277                                                                                                         |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                      |  |                                                                                                                              | 23b. DATE<br>01-29-83                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK                                                                                                    |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND       |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 24b. ADDRESS<br>21229                                                                                                                                |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983                             |                                                                                                                            |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |                                                                     |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br>John J. Conish                                                                                                         |                                                                                      |                                                                          |                                                                                                                            |                                                                                                 |  |

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*[Faint, mostly illegible text on lined paper, possibly a form or document.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 4 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                         |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE CATHERINE GORDON                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-15-83                                |                                                                                         | 2b. HOUR<br>4:05 AM                                                                                                           |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>WHITE                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 22, 1906                                                                                                        |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 yrs.                                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WISCONSIN                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                              |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE CITY OR TOWN<br>MARYLAND BALTO, DUNDALK                                                                                                                                                                                                       |                                                                                                                                      | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13c. STREET ADDRESS<br>7046 BELCLARE RD. 21222                                |                                                                                         |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MARTIN E. BERG                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE ANDERSON                                                                                             |                                                                               |                                                                                         |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                    |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>216.24.0114                                                                                                                     |                                                                               | 17. INFORMANT<br>ADDRESS<br>ROBERT D. GORDON 20 EASTSHIP RD.<br>DUNDALK, MARYLAND 21222 |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4280 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                         |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                      |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                         |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)          |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 28, 1982</u> to <u>JANUARY 15, 1983</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 15, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                         |                                                                                                                               |
| 22b. SIGNATURE<br>Carl Sperling MD                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | DEGREE<br>MD                                                                                                                                                |                                                                               | 22c. DATE SIGNED<br>1/15/83                                                             |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CARL SPERLING, M.D.                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 22e. ADDRESS<br>201 E. UNIVERSITY PKWY BALTO 21218                                                                                                          |                                                                               |                                                                                         |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 23b. DATE<br>1/18/1983                                                                                                                                      |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.                              |                                                                                                                               |
| 23d. LOCATION<br>(CITY OR TOWN)<br>ELKRIDGE                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | COUNTY<br>MARYLAND                                                                                                                                          |                                                                               | STATE                                                                                   |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., DUNDALK, MD. 21222                                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                  |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                  |

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1971

CONFIDENTIAL - A.D. 1971

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(V/R A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                      |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------|--|-------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michael C. Gough</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                      |  |                                                                                                                                      |  |                                                                        |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 4 1983</b> |  | 2b. HOUR <b>8:30</b>                                                                         |  |                      |  |                                                 |  |  |  |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 23 66</b>                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>16</b> YRS.                         |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN                                                                              |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 4 1983</b>                                   |  | 2d. HOUR <b>8:30</b> |  |                                                 |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                           |  |                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                   |  |                      |  |                                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1313 N. Woodington</b> |  |                                                                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                      |  |                                                 |  |  |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                      |  | 13b. COUNTY                                                                                                                          |  |                                                                        |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                       |  |                                                                                                         |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |                      |  | 13e. STREET ADDRESS <b>460 Oxford Ct. 21201</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Reginald Gough</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Jacqueline Turner</b> |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. <b>213-84-9608</b>                            |  |                                                                                                                                                          |  |                                                                                                         |  | 17. INFORMANT ADDRESS <b>Jacqueline Gough 460 Oxford Ct.</b>                                 |  |                      |  |                                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Gunshot Wound Chest</b><br>IMMEDIATE CAUSE (a) <b>9654</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |                      |  |                                                                                                                                      |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                      |  |                                                                                                                                      |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                    |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |                      |  |                                                 |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>8:15</b> MONTH <b>1</b> DAY <b>4</b> YEAR <b>1983</b>                                                 |  |                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subj shot during altercation</b>                                        |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>                                                             |  |                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>1313 N. Woodington, Balto, Md.</b>                                                                  |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |                                                                                                                                      |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>                                                                                                     |  |                                                                        |  | M.D. <b>Assistant</b>                                                                                                                                    |  |                                                                                                         |  | DATE SIGNED <b>15/ 83</b>                                                                    |  |                      |  |                                                 |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                      |  | ADDRESS <b>111 Penn St., Balto, Md.</b>                                                                                              |  |                                                                        |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                                              |  |                      |  |                                                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 23b. DATE <b>1/8/83</b>                                                                                                              |  |                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>                                                                                            |  |                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Co. md.</b>                          |  |                      |  |                                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 e. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                 |  |                      |  |                                                                                                                                      |  |                                                                        |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1983</b>                                                                                                          |  |                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Gough</b>                                              |  |                      |  |                                                 |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                                                         |  | REG. NO. 83 00942                                                                                   |  |                                                    |  |                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LAURELL I. GRADY</b> |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 21 83</b> |  | 2b. HOUR<br><b>10 38 AM</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>caucasian</b>                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 26 17</b>                                                                                                           |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>65</b>                                             |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>                                                                            |  | 8. IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>                                                        |  |                                                    |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city MD.</b>                            |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore city</b>                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietician</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                                                                      |  |                                                                                                     |  |                                                    |  |                             |  |
| 13a. STATE<br><b>Meryland</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | 13b. COUNTY<br><b>Ba</b>                                                                                                                                    |                                                                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5528 Emory Rd. 21155</b>                                                                      |  |                                                                                                     |  |                                                    |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Adolph Seible</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mabel Davis</b>                                                                                            |                                                                               |                                                                                              |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>               |  |                                                                                                     |  |                                                    |  |                             |  |
| 16a. SOCIAL SECURITY NO.<br><b>218-09-7675</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |  | 17. INFORMANT ADDRESS<br><b>Mr. Robert P. Grady, Upperco, Md.</b>                                                                                           |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>1539 IMMEDIATE CAUSE (a) Staph Aureus Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>immunosuppression</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic cc of colon</b> |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>2 months</b><br><b>2 months</b> |  |                                                    |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>glucose intolerance</b>                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             |                                                                               | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                     |  |                                                    |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 7</b> , 19 <b>83</b> , to <b>JAN 21</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>JAN 21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                      |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 22b. SIGNATURE<br><b>Robert M. Cooper</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                               |                                                                                              |  | 22c. DATE SIGNED<br><b>1/21/83</b>                                                                                      |  |                                                                                                     |  |                                                    |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert M. Cooper</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  | 22e. ADDRESS<br><b>Sinai Hospital</b>                                                                                                                       |                                                                               |                                                                                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>1-24-83</b>                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                              |                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |                                                                                                                         |  |                                                                                                     |  |                                                    |  |                             |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Eline Funeral Home, Hampstead, Md. 21074</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                                                     |  |                                                                                                     |  |                                                    |  |                             |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 4 3

1. FOR  
STATE  
REGISTRAR

Raymond

REG. NO.

|                                                                                        |                                                                                                                                  |                                                                                                                                                             |                                                                                |                                                     |                                                                  |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Raymond ALLAN GRAINGER SR. |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 2 83                                  |                                                     | 2b. HOUR<br>4 45 P.M.                                            |
| 3. SEX<br>MALE                                                                         | 4. RACE<br>WHITE                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4/27/1911                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                     |                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MISSOURI                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                     |                                                                  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>IRONWORKER | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION   |                                                                  |
| 13a. STATE<br>MARYLAND                                                                 |                                                                                                                                  |                                                                                                                                                             | 13b. CITY OR TOWN<br>WATERSEDGE                                                | 13c. STREET ADDRESS<br>8229 PEACH ORCHARD RD. 21222 |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN S. GRAINGER                             |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JESSE WEITZ                                                                                                |                                                                                |                                                     |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES            |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.11                                                                                           | 17. INFORMANT<br>ADDRESS<br>FRANCES C. GRAINGER SAME AS 13c.                   |                                                     |                                                                  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

|                                                                                                         |                                       |                |                                                           |
|---------------------------------------------------------------------------------------------------------|---------------------------------------|----------------|-----------------------------------------------------------|
| 4415                                                                                                    | IMMEDIATE CAUSE (a)                   | CARDIAC Arrest | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 min |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF<br>(b) |                | 4 hrs                                                     |
|                                                                                                         | DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                | 3 wks                                                     |
|                                                                                                         |                                       |                |                                                           |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Aortic Aneurysm, Ruptured

|                                                                                                                                                          |                                                                        |                                                                                                     |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br>11-15-82                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ruptured Aneurysm  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>Ruptured Aneurysm |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>22 S. Greene St                                |                                                                                                                               |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did) (did not) view the body after death.

|                                                    |                                 |                                                                                                                                            |
|----------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 22b. SIGNATURE<br>S. Mangiante                     | DEGREE                          | 22c. DATES SIGNED<br>1/2/83                                                                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MANGIANTE | 22e. ADDRESS<br>22 S. Greene St | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |

|                                                             |                       |                                                              |                                                          |
|-------------------------------------------------------------|-----------------------|--------------------------------------------------------------|----------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL      | 23b. DATE<br>1/5/1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL CEMETERY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC. |                       | 25. DATE REC'D. BY REGISTRAR<br>JAN 5 1983                   |                                                          |
| ADDRESS<br>DUNDALK, MD. 21222                               |                       | BY REGISTRAR'S SIGNATURE<br>John J. Conner                   |                                                          |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FILE

20% SECTION



HAC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00944

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>COLUMBUS GRANT</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 13 83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>12:00P<sub>M</sub></b>                                                           |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                            |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 6 32</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC LOCH RAVEN BLVD. BALTO MD</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                       |                                                       | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>341 Camp St. 21218</b>                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fulton Grant</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Wright</b>                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>215 28 4309</b>                                                                                                     |                                                       | 17. INFORMANT<br><b>Ethel Palmer</b>                                                                                                                        |  | ADDRESS<br><b>341 Camp St.</b>                                                                  |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulm arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypoxic brain death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>aspiration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5</b>                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>hypoglycemic event, dysphagia</b>                                                                                                                                                                                                                               |  |                                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>January 13, 1983</b>                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>hypoglycemic event, dysphagia</b>                                                           |                                                       |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                       |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3900 Loch Raven Blvd. Balto. Md 21218</b>                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>December 23, 1982</b> to <b>January 13, 1983</b> , that (X) we last saw the deceased alive on <b>January 13, 1983</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) we did (not) view the body after death.                                                               |  |                                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Beverly J. Kelsey MD</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |                                                       | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>1/13/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Beverly Kelsey</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                    |                                                       | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md 21218</b>                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>1/17/83</b>                                                                                                                        |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                    |                                                       | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>                                                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

MR MORRIS C GRANT

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00945

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             |                                                                                                                             |                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| FOR<br>1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             | REG. NO.                                                                                                                    |                                                                                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MORRIS C. GRANT, Sr.</b>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/1/83</b><br>2b. HOUR<br><b>1:38 PM</b>                                          |                                                                                    |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>White</b>                                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 18 12</b>                                                                       |                                                                                    |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                                                                                                                                                                                                                                                                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY 21218</b> MD.            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL 21218</b>           |                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | 13b. COUNTY                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                              |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 13e. STREET ADDRESS<br><b>818 W. 32nd. Street 21211</b>                                                                     |                                                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Grant</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Wheeler</b>                                                   |                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>216-07-2491</b>                                                                              |                                                                                    |
| 17. INFORMANT<br><b>Mr. Morris Grant, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | ADDRESS<br><b>818 W. 32nd. Street 21211</b>                                                                                 |                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4151</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest / Pulm Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Deep venous thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Junk</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>                                                              |                                                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Organic Brain Syndrome, hypertension</b>                                                                                                                                                                                                                             |                                                                                                                                                             |                                                                                                                             |                                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |                                                                                    |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>                                                               |                                                                                    |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |                                                                                    |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                           |                                                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/82</b> to <b>1/1/83</b> , that (I) (we) last saw the deceased alive on <b>1/1/83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.                                                                                           |                                                                                                                                                             |                                                                                                                             |                                                                                    |
| 22b. SIGNATURE<br><b>Paul Miller MD</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | 22c. DATE SIGNED<br><b>1/1/83</b>                                                                                           |                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL MILLER M.D.</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                             | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                              |                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             | 23b. DATE<br><b>1/5/83</b>                                                                                                  |                                                                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Vernon United Meth.Ch.</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Whitehall Maryland</b>                                                     |                                                                                    |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>A. Alan Seitz, Jr. 3818 Roland Ave. 21211</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>5198</b>                                                                                |                                                                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                             |                                                                                                                             |                                                                                    |

BP



|                                                       |       |       |       |           |         |
|-------------------------------------------------------|-------|-------|-------|-----------|---------|
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
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| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |
| 215-07-2491 Mr. Morris Grant, Jr. 618 W. 32nd. Street | 21511 | Heery | Grant | Elizabeth | Wheeler |

PAUL MILLER M.D.  
 Union Memorial Hospital  
 175/43  
 Vernon United Meth. Ch. Whitehall  
 Maryland

A. Alan Seitz, Jr. 3818 Roland Ave. 21511

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 0 9 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

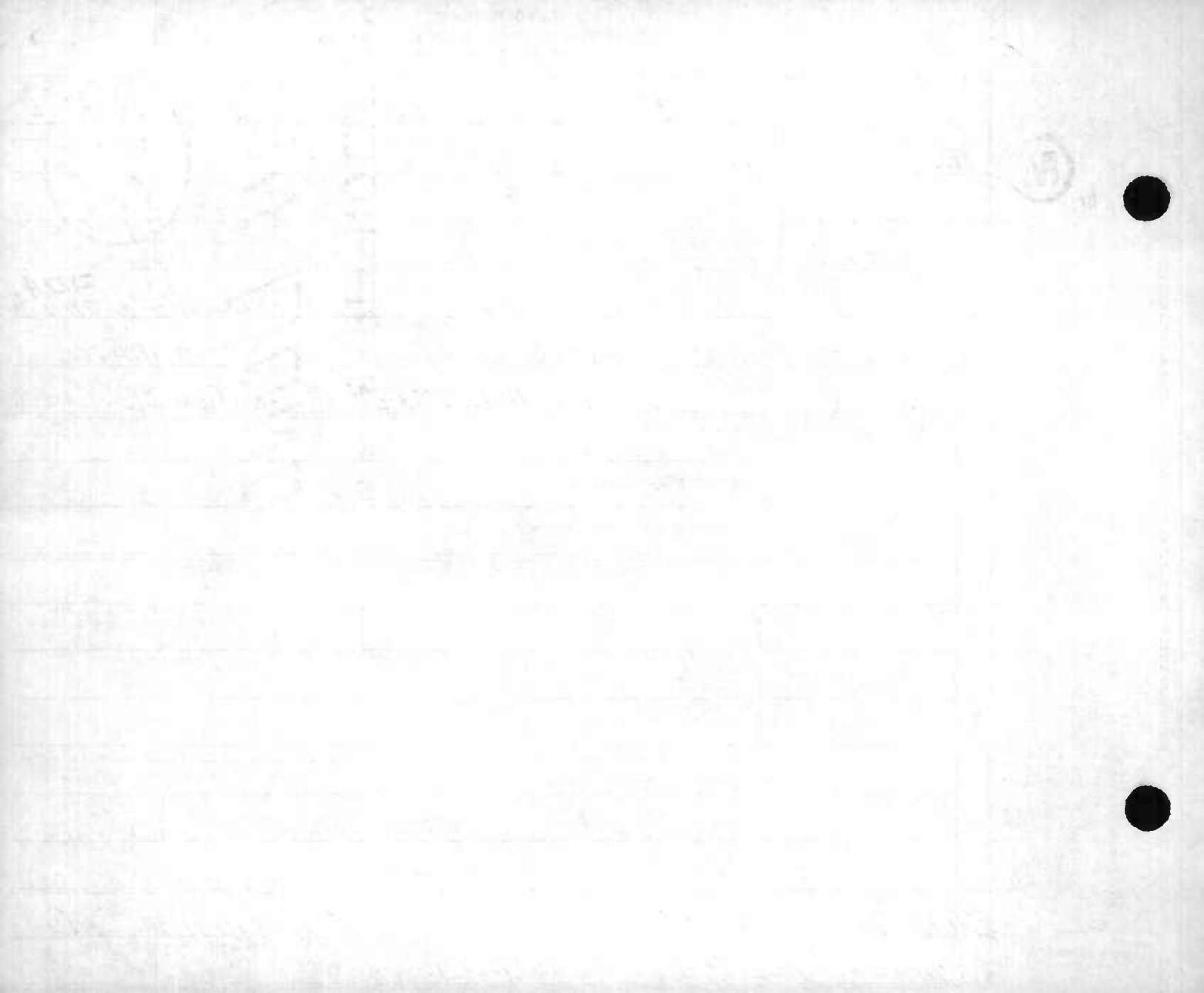
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|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Thomas J. Gratton JR.                                                                        |  |                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 18 83 |                                                                                                                                                             |  | 2b. HOUR<br>8' 4 M                                                                                                                                                                                                                                                                    |  |
| 3. SEX<br>Male                                                                                                                                        |  | 4. RACE<br>White                                                                                                               |                                             | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 17 04                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78                                                                                                                                                                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Unknown                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                           |                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>City, Balto.                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |                                             |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                                                                                                                                                                                                              |  |
| 13a. STATE<br>Md.                                                                                                                                     |  | 13b. COUNTY<br>—                                                                                                               |                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank Louis Thomas J. Gratton                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown Agnes M. Mahon                                                           |                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                      |  |                                                                                                                                                                                                                                                                                       |  |
| 16b. SOCIAL SECURITY NO.<br>21464 9187                                                                                                                |  | 17. INFORMANT ADDRESS<br>MARGARET M. GRATTON 513 S. LAKEWOOD                                                                   |                                             |                                                                                                                                                             |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Uremia<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.                     |  |                                                                                                                                |                                             |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                                                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  | 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22a. SIGNATURE<br>S. Suwanagool                                                                                                                       |  | DEGREE                                                                                                                         |                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/18/83                                                                                                                                                                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. SUWANAGOOOL                                                                                               |  | 22e. ADDRESS<br>Lutheran Hospital                                                                                              |                                             | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                         |  |                                                                                                                                                                                                                                                                                       |  |
| 23b. DATE<br>1/22/83                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD                                                                                 |                                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.                                                                                                    |  | 24. FUNERAL DIRECTOR NAME<br>RAYMOND L. KACZOROWSKI 2525 FLEETS                                                                                                                                                                                                                       |  |
| 24b. ADDRESS                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1983                                                                                   |                                             | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                                                                                |  |                                                                                                                                                                                                                                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called or notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00947

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                           |                                                                                                                                                |                                                                                                                                                             |                                                                                                     |                                                                   |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET W. GRAVES</b>                                                          |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/04/83</b>                                              |                                                                   | 2b. HOUR<br><b>5:55p</b>                                        |
| 3. SEX<br><b>Female</b>                                                                                                   | 4. RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 15, 1901</b>                                                                                                   |                                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Marion, N.C.</b>                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Administrative Assistant</b> |                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>D.C.</b> |                                                                                                                                                | 13b. CITY OR TOWN<br><b>Washington</b>                                                                                                                      | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                | 13d. STREET ADDRESS<br><b>110-D- Street S.E. #314</b>             |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George I. White</b>                                                          |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Sinclair</b>                                                                                       |                                                                                                     |                                                                   |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>                                                                         | 17. INFORMANT<br>ADDRESS<br><b>Washington, D.C. 20003</b><br><b>Shirley G. Cochrane-daughter Box 8862</b>                                                   |                                                                                                     |                                                                   |                                                                 |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

**MYOCARDIAL INFARCTION**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 HOUR

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **CORONARY ARTERY DISEASE**

20 YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**STATUS POST SPHINGTEROTOMY**

|                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                |  |                                                                                      |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>1/4/83</b>                                                                                                                                                                                                                                                                                                                         |                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PAPILLARY STENOSIS</b>  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>                                                                                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                      |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                      |                                                                                                                               |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>83</b> , to <b>1/4</b> , 19 <b>83</b> , that (1) (we) lost<br>saw the deceased alive on <b>1/4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) not view the body after death. |                                                                        |                                                                                |  |                                                                                      |                                                                                                                               |
| 27b. SIGNATURE<br><b>Neil M. Bressler</b>                                                                                                                                                                                                                                                                                                                       |                                                                        | DEGREE<br><b>MD</b>                                                            |  | 27c. DATE SIGNED<br><b>1/4/83</b>                                                    |                                                                                                                               |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NEIL M. BRESSLER</b>                                                                                                                                                                                                                                                                                                |                                                                        | 27e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                  |  |                                                                                      |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>1-9-83</b>                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                |                                                                                                                               |

## 24. FUNERAL DIRECTOR

NAME  
**Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002**

## 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

**26 JAN 11 1983 John J. Carver**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



George I. State Mary  
D.C. Washington  
House of Representatives (Rep.)  
110-0-00000-00000-00000  
Washington, D.C. 20543  
110-0-00000-00000-00000  
Washington, D.C. 20543

Washington, D.C. 20543

110-0-00000-00000-00000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 4 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 |                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY GRAY</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/10/83</b>           |                                                                                                 | 2b. HOUR<br><b>4:20 PM</b>                                                          |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>Black</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 26 13</b>                                                                                                              |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b><br>YRS. MONTHS DAYS                                |                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | 13b. COUNTY                                                                                                                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Gray</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Brown</b>                                                                                               |                                                                  |                                                                                                 |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-14-3244</b>                                                                                     |                                                                  | 17. INFORMANT ADDRESS<br><b>Elizabeth K. Gregory 2248 Cecil Avenue</b>                          |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous cell carcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>unknown</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                  |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                  |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                     |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 |                                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                        |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                            |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>83</b> , to <b>1-10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 |                                                                                     |
| 22b. SIGNATURE<br><b>Andre Brugh</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                  | 22c. DATE SIGNED<br><b>1-10-83</b>                                                              |                                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andre Brugh</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                                     |                                                                  |                                                                                                 |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                | 23b. DATE<br><b>1/13/83</b>                                                                                                                                       |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                                   |                                                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                |                                                                                                                                                                   |                                                                  |                                                                                                 |                                                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                              |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>                                             |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                               |                                                                  |                                                                                                 |                                                                                     |

RELEASED AS NON-MED DR. SMYTH PER MR PURVIS

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ex-tem, it shows any injury, or other traumatic event, the medical examiner should be notified.

MAY 22 1960 210 F

RECEIVED  
MAY 22 1960

RECEIVED MAY 22 1960

RECEIVED

MAY 22 1960

RECEIVED MAY 22 1960

RECEIVED

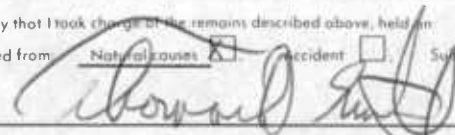
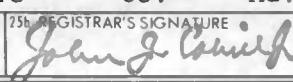
RECEIVED MAY 22 1960

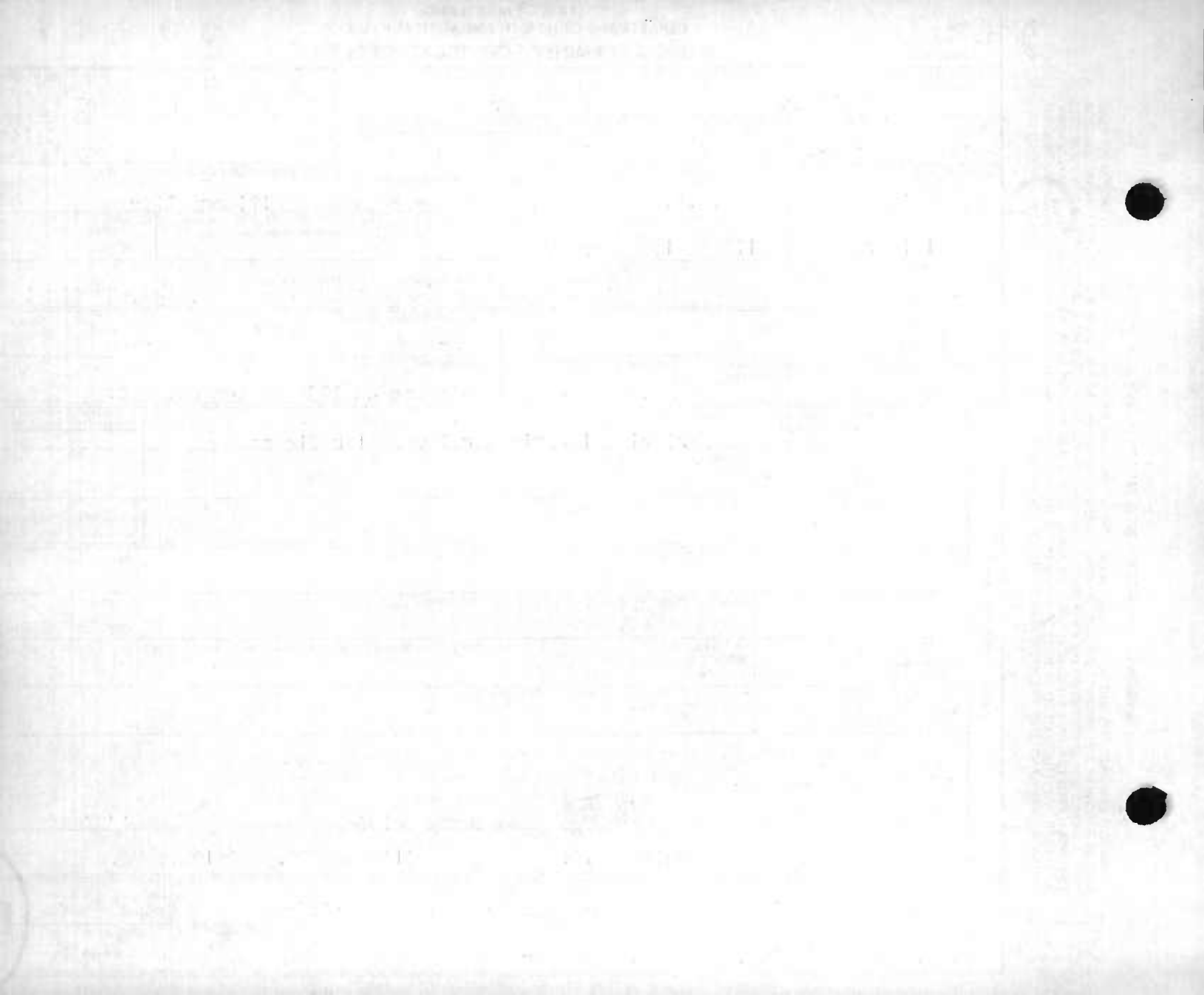


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | REG. NO. 83 00949                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                  |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Edward Green                                                                                                                                                                                                                                                                                                                                                                        |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 3 1983 |                                                                                                                  | 2b. HOUR M 9:14A                                         |                                                                                                                                    |  |
| 3. SEX male                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE Black |                                                                                                                            | 5. DATE OF BIRTH MONTH DAY YEAR 2 5 08                      |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.                                                                                                                  |                                                                                               | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                         |                                                          | 2c. DATE PRONOUNCED DEAD 1 3 1983                                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia                                                                                                                                                                                                                                                                                                                                                                   |  |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                        |                                                             |                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                               |                                                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. |                                                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                     |  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 Bolton Street |                                                             |                                                         |                                                                                                                                                          |                                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                    |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                  |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                                     |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | 13b. COUNTY Baltimore                                                                                                              |  |
| 13c. CITY OR TOWN Baltimore                                                                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS 1100 Bolton St. Apt. 909 21201                                                                                                                                                                                                                                                                                                                                                                      |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN                                                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                            |                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Green |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                   |  |               | 16b. SOCIAL SECURITY NO. 217-03-2006                                                                                       |                                                             |                                                         | 17. INFORMANT ADDRESS Elsie Jordan 1100 Bolton St. Apt. 909                                                                                              |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                     |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |  |               |                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |  |               |                                                                                                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  |               |                                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held in death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                             |  |               |                                                                                                                            |                                                             |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                      |  |               |                                                                                                                            | TITLE (SPECIFY) M. Deputy Chief MEDICAL EXAMINER            |                                                         |                                                                                                                                                          |                                                                                               | DATE SIGNED 1/3/83                                                                                               |                                                          |                                                                                                                                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                   |  |               |                                                                                                                            | ADDRESS 111 Penn St. Balto., MD.                            |                                                         |                                                                                                                                                          |                                                                                               |                                                                                                                  |                                                          |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                        |  |               | 23b. DATE 1/7/83                                                                                                           |                                                             | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.    |                                                                                                                                                          |                                                                                               | 23d. LOCATION CITY OR TOWN Baltimore                                                                             |                                                          | COUNTY Co. STATE Md.                                                                                                               |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. ADDRESS 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                            |  |               |                                                                                                                            |                                                             |                                                         | 25a. DATE REC'D. BY REGISTRAR JAN 6 1983                                                                                                                 |                                                                                               | 25b. REGISTRAR'S SIGNATURE  |                                                          |                                                                                                                                    |  |



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove card(s) properly. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                                        | 8300950<br>REG. NO.                                                                                                                                         |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>REUBEN GREEN</b>                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 9, 1983</b>                                                                                                  |                                                                   |                                                                                                 |                                                                                  | 2b. HOUR<br><b>11 A. M.</b>                                                                                                |  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>WHITE</b>                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 14, 1918</b>                                                                                                 |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                               |                                                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.                        |                                                                                  |                                                                                                                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5903 SIMMONDS AVE. 21215</b> |                                                                        |                                                                                                                                                             |                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMPLOYED</b>        |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GROCER</b>                                                                         |  |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                              |                                                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                  | 13e. STREET ADDRESS<br><b>5903 SIMMONDS AVE. 21215</b>                                                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN GREEN</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA HALLAM</b>                                                                                          |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>217-26-4765</b>                                                                                               |                                                                        | 17. INFORMANT<br><b>MR. ISADORE GREEN</b>                                                                                                                   |                                                                   | ADDRESS<br><b>5903 SIMMONDS AVE. 21215</b>                                                      |                                                                                  |                                                                                                                            |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Myocardial Infarction</b>                                                                                                                                                          |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                                                              |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Artery Disease (atherosclerosis)</b>                                                                                                                                                                     |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  | 1 month                                                                                                                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                       |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                  |                                                                                                                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                  |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                  |                                                                                                                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/9/82</b> to <b>1/9/83</b> , that (I) (we) last saw the deceased alive on <b>12/9/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) had) (did not) view the body after death. |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
| 22b. SIGNATURE<br><b>John P. Urlock, Jr MD</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | DEGREE<br><b>MD</b>                                               |                                                                                                 | 22c. DATE SIGNED<br><b>1/10/83</b>                                               |                                                                                                                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. JOHN URLOCK, JR</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>1227 WASHINGTON BLVD.</b>                      |                                                                                                 |                                                                                  |                                                                                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                              | 23b. DATE<br><b>1/10/83</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>TIFERETH ISRAEL CEM.</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTIMORE MARYLAND</b> |                                                                                                                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Carver</b>                                |                                                                                                                            |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                   |                                                                                                 |                                                                                  |                                                                                                                            |  |  |

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## MEDICAL CERTIFICATION



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 0 9 5 2  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                             |                                                                  |                                                                                      |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES LEE GREGG                                                                                                                                                                                                                                                                                                          |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 17 83                   |                                                                                      | 2b. HOUR<br>1:25P M                                                                                                        |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br>Black                                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 24 36                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.                       |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD        |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC LOCH RAVEN BLVD. BALTO. MD |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              |                                                                                                                                                             | 13b. COUNTY                                                      | 13c. CITY OR TOWN<br>Baltimore                                                       |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eddie Gregg                                                                                                                                                                                                                                                                                                           |                                                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Glendora Lester |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES                                                                                                                                                                                                                                                         |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>216-30-9688                                                                                                                     | 17. INFORMANT<br>ADDRESS<br>Rose L. Webb 3118 E. Federal Street  |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) metastatic colon cancer<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                              |                                                                                                                                                             |                                                                  |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years                                                                    |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                             |                                                                                                                                              |                                                                                                                                                             |                                                                  |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that X (this hospital) attended the deceased from January 15, 19 83, to January 17, 19 83, that X (we) last saw the deceased alive on January 17, 19 83, and that in X (our) opinion death occurred on the date and hour and from the causes stated above, X (we) did (and) view the body after death.                                           |                                                                                                                                              |                                                                                                                                                             |                                                                  |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>Judeh Minkove MD                                                                                                                                                                                                                                                                                                                              |                                                                                                                                              | DEGREE<br>MD                                                                                                                                                |                                                                  | 22c. DATE SIGNED<br>11/17/83                                                         |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Judeh Minkove                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto. Md 21218                                                                                                       |                                                                  |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 23b. DATE<br>1/24/83                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cemetery       |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Md.                                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                                                      |                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983                                                                                                                |                                                                  | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Smith                                          |                                                                                                                            |

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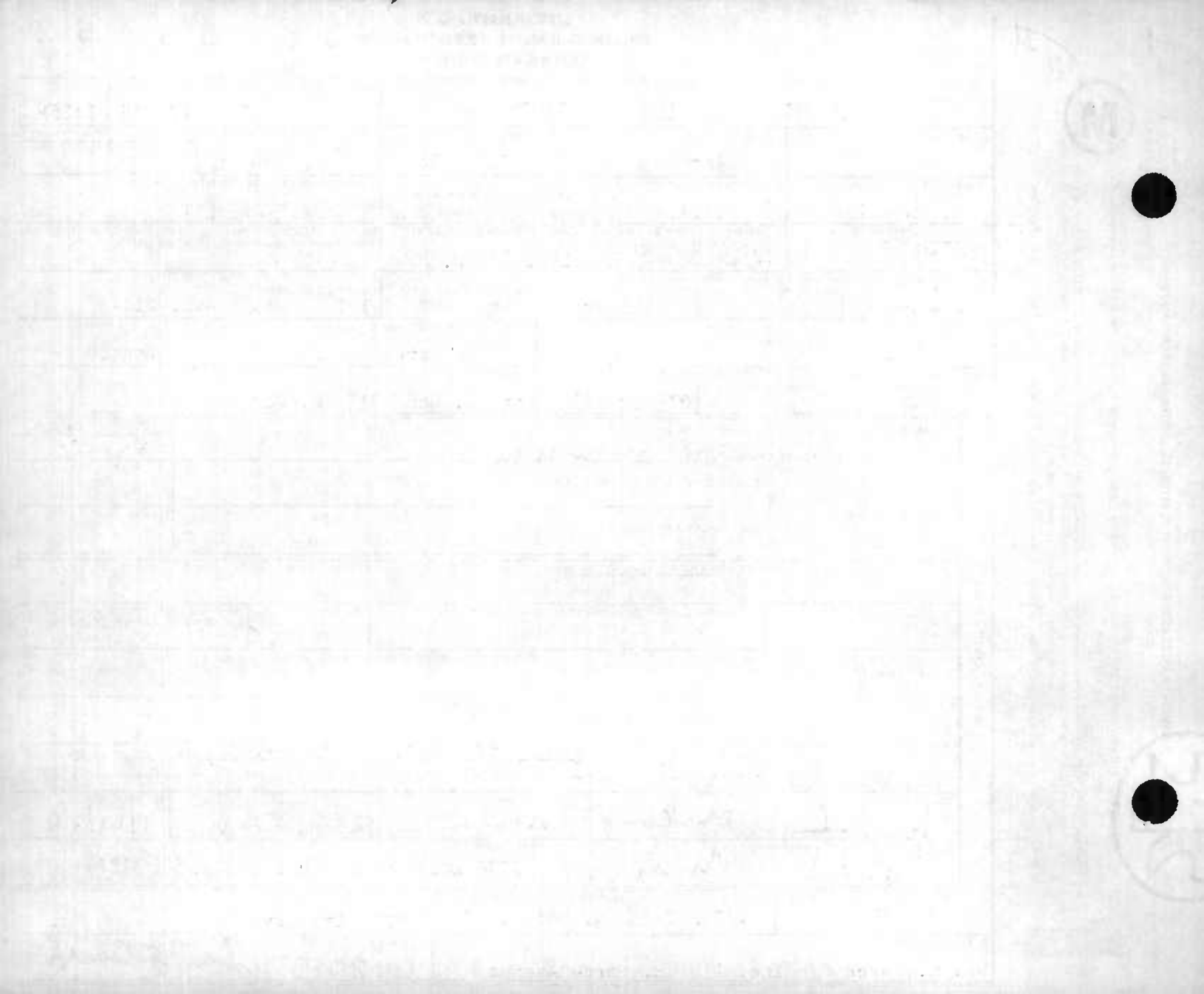
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00953

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Norma TERESA GREGG                                                                                                                                                                                                                                                                   |  |                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 17 1983                                                                                                   |                                                                                                                                                             |                                                                                | 2b. HOUR<br>6:30 A.M.                                                     |                                                                                                 |                                                                                                                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>Black                                                                                                                |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 9 04                                                                                                                |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.                          |                                                                                                 |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE City                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>M.F. Nursing Home. |                                                                                                                                                      |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 13b. COUNTY                                                                                                                                          |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Cokley                                                                                                                                                                                                                                                                       |  |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Perry                                                                                          |                                                                                                                                                             |                                                                                | 13e. STREET ADDRESS<br>4320 Clareway Apt. 6D 21213                        |                                                                                                 |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>245-01-9507                                                          |                                                                                                                                                      | 17. INFORMANT<br>ADDRESS<br>Pedrie C. Davis 49 Pennsylvania Ave. Apt. 4                                                                                     |                                                                                |                                                                           | 17b. BUFFER, NY. 14201                                                                          |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1844 IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma Vulva with metastases<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) months +.                                            |  |                                                                                                                                 |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                         |  |                                                                                                                                 |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                           |                                                                                                 |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                           |                                                                                                 |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Jan, 1983, to 17 Jan, 1983, that (I) (we) lost<br>saw the deceased alive on 16 Jan 83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (do not) view the body after death. |  |                                                                                                                                 |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                               |  |
| 22b. SIGNATURE<br>Edmund S. Beacham MD                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br>17 Jan 83                                             |                                                                                                 |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. G. BEACHAM M.D.                                                                                                                                                                                                                                                                 |  |                                                                                                                                 | 22e. ADDRESS<br>Baltimore City Hospitals.                                                                                                            |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 23b. DATE<br>1/22/83                                                                                                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                       |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD.                                     |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D BY REGISTRAR<br>JAN 18 1983                                    |                                                                           | 25b. REGISTRAR'S SIGNATURE<br>John J. Casper                                                    |                                                                                                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                  |  |                                                                               |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------|--|----------------------------|--|------------------|--|--------------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                   |  | FIRST                                                                                                            |  | MIDDLE                                                                        |  | LAST                                 |  | 2a. DATE KNOWN<br>OF DEATH |  | ESTIMATED        |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| NORMAN                                                                                                                                                                                                                                                                                                                |  | H.                                                                                                               |  | GREGORY                                                                       |  |                                      |  | DATE KNOWN<br>OF DEATH     |  | ESTIMATED        |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| 1. SEX                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                          |  | 5. DATE OF BIRTH                                                              |  | 6. AGE (IN YEARS)                    |  | IF UNDER 1 YR.             |  | IF UNDER 24 HRS. |  | 2c. DATE<br>PRONOUNCED<br>DEAD       |  | MONTH |  | DAY  |  | YEAR     |  |
| M                                                                                                                                                                                                                                                                                                                     |  | W                                                                                                                |  | 3/14/14                                                                       |  | 68                                   |  | MONTHS                     |  | DAYS             |  | 1                                    |  | 9     |  | 1883 |  | 11:38    |  |
| 7. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                     |  | 8. MARRIED                                                                    |  | NEVER MARRIED                        |  | WIDOWED                    |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                             |  | U. S. A.                                                                                                         |  | MARRIED                                                                       |  | NEVER MARRIED                        |  | WIDOWED                    |  | DIVORCED         |  | Baltimore City                       |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)       |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>OR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                             |  | South Baltimore Gen. Hospital                                                                                    |  | Electronics (Retired)                                                         |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                      |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?             |  | 13e. STREET ADDRESS        |  |                  |  |                                      |  |       |  |      |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                  |  | Baltimore                                                                     |  | YES                                  |  | 2904 Heron St.             |  |                  |  |                                      |  |       |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                     |  | FIRST                                                                                                            |  | MIDDLE                                                                        |  | LAST                                 |  | 15. MOTHER'S MAIDEN NAME   |  | FIRST            |  | MIDDLE                               |  | LAST  |  |      |  |          |  |
| Dennis Gregory                                                                                                                                                                                                                                                                                                        |  |                                                                                                                  |  |                                                                               |  |                                      |  | Minnie Kent                |  |                  |  |                                      |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.                                                                                         |  | 17. INFORMANT                                                                 |  | ADDRESS                              |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| No.                                                                                                                                                                                                                                                                                                                   |  | 312-01-4789                                                                                                      |  | Mrs. E. Gregory                                                               |  | 2904 Heron St.                       |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>(c) _____ |  |                                                                                                                  |  |                                                                               |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                  |  |                                                                               |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                   |  |                                                                                                                  |  |                                                                               |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                |  | 20. AUTOPSY?                                                                  |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                  |  | YES                                                                           |  | NO                                   |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                   |  | 21f. LOCATION<br>STREET                                                       |  | CITY OR TOWN                         |  | COUNTY                     |  | STATE            |  |                                      |  |       |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                  |  |                                                                               |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> |  | and in my opinion                                                             |  |                                      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                   |  | Deputy Chief                                                                                                     |  | MEDICAL EXAMINER                                                              |  | DATE<br>SIGNED                       |  | 1-10-83                    |  |                  |  |                                      |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  | Thomas D. Smith, M.D.                                                                                            |  | ADDRESS                                                                       |  | 111 Penn St., Balto., Md. 21201      |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION<br>CITY OR TOWN        |  | COUNTY                     |  | STATE            |  |                                      |  |       |  |      |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                                |  | 1/13/83                                                                                                          |  | Mt. Olivet Cemetery                                                           |  | 2930 Fulewood Rd.                    |  | Baltimore                  |  | Md.              |  |                                      |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  | 25b. REGISTRAR'S SIGNATURE           |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |
| John J. Conner                                                                                                                                                                                                                                                                                                        |  | 1501 E. Fort Ave.                                                                                                |  | JAN 13 1983                                                                   |  | John J. Conner                       |  |                            |  |                  |  |                                      |  |       |  |      |  |          |  |



NOTED 213

213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                           |  |                                                                                                                       |  | 8 3 0 0 9 5 5                                                                                                                                               |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  |                                                                                                                       |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>James John Grem                                                                                                                                                                                                                                       |  |                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 27 83                                                                                                                 |  | 2b. HOUR<br>12 05 A                                                                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>Caucasian                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 22 97                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>85 8 00                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>BALTO., Md.                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY, MD.                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE, GIVE ADDRESS)<br>BALTIMORE CITY HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORKING LIFE)<br>Retired                                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O R.R.                                                                            |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br>—                                                                                                      |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE<br>Vincent Brock                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Sophia Bernadzkiowski                                                        |  | 13e. STREET ADDRESS<br>414 S. Drew Street                                                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>705-05-5594                                                                               |  | 17. INFORMANT ADDRESS<br>Frances L. Grem 414 S. Drew St. 21224                                                                                              |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4276 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                      |  |                                                                                                                       |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                             |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 83 to 1/27 19 83, that (I) (we) last saw the deceased alive on 1/26 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>M. Ferguson MD                                                                                                                                                                                                                                                                               |  |                                                                                                                       |  | DEGREE<br>MD                                                                                                                                                |  | 22c. DATE SIGNED<br>1/27/83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FURGERSON MD                                                                                                                                                                                                                                                          |  |                                                                                                                       |  | 22e. ADDRESS<br>BALTO CITY HOSP.                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                            |  | 23b. DATE<br>1-29-83                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Cem.                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk, Balto. Co., Md.                                                     |  |
| 24. FUNERAL DIRECTOR<br>C.S. Zeiler & Son Inc. 6224 Eastern Avenue                                                                                                                                                                                                                                             |  |                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canish                                                                               |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  | REG. NO. 3 3 00956                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |
| 2. DECEASED NAME FIRST MIDDLE LAST JULIA Joan GRIBUS                                                                                                                                                                                                                                                                                                                                                                                                   |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 1-29-83 19 |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 1-6-1913                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.                                                      |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN.                                                       |  |
| 7a. BIRTHPLACE (STATE OR TERRITORY) Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                     |  |                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                    |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4402 Springwood |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailoring                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY Retired                                         |  |
| 13a. STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore                                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 4402 Springwood Ave.-21206                                                                                                           |  |                                                                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Supko                                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  |                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine                                         |  |                                                                                                                                                          |  |                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                                  |  |               |  | 16b. SOCIAL SECURITY NO. 209-07-6746                                                                                    |  | 17. INFORMANT ADDRESS Mrs. Joan C. Miskimon - 4311 Edro A.e. - 21236                         |  |                                                                                                                                                          |  |                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                              |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                     |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                       |  |                                                                                              |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |  |                                                                                                                                                          |  |                                                                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                        |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                             |  | 21f. LOCATION STREET                                                                         |  | CITY OR TOWN                                                                                                                                             |  | COUNTY STATE                                                                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  | TITLE (SPECIFY) M.D. Assistant                                                                                          |  |                                                                                              |  | DATE SIGNED 1-30-83                                                                                                                                      |  |                                                                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Lorell, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |  |               |  | ADDRESS 111 Penn Street                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  | 23b. DATE 2-2-83                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem                                      |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                           |  |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc                                                                                                                                                                                                                                                                                                                                                                                                           |  |               |  | ADDRESS 6415 Belair Rd.-21206                                                                                           |  |                                                                                              |  | 25. DATE REC'D. BY REGISTRAR JAN 31 1983                                                                                                                 |  |                                                                                   |  |
| REGISTRAR'S SIGNATURE John J. Casper                                                                                                                                                                                                                                                                                                                                                                                                                   |  |               |  |                                                                                                                         |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |



*[Faint, illegible text and markings are visible throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  | REG. NO. 83 00957 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Grier</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-29-83</b>                                           |  | 2b. HOUR<br><b>10<sup>52</sup> P.M.</b>                                                                                    |  |                   |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Black</b>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 15 08</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |                                                                                                                            |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2219 Braddish Avenue 21216</b>                                                                   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Grier</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Herbert</b>                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>704-18-3381</b>                                                                               |  | 17. INFORMANT<br>ADDRESS<br><b>Viola Spencer 2960 Mosher St. Apt. 4B</b>                        |  |                                                                                                                            |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>sino-atrial node arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pneumonia + COPD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min.</b><br><b>20 days</b><br><b>7 days</b> |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>protein-calorie malnutrition; myocardial irritability; cor pulmonale</b>                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1-17</b> 19 <b>83</b> to <b>1-27</b> 19 <b>83</b> , that (I) (we) last saw the deceased on <b>1-27</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 22b. SIGNATURE<br><b>Stephen R. Smith, MD</b><br>DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                          |  |                                                                                                                                          |  |                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>1-28-83</b>                                                              |  |                                                                                                                            |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN R. SMITH, MD</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>2000 W. BALTIMORE ST., BALTIMORE 21223</b>                                   |  |                                                                                                                            |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>2/3/83</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shady Grove Bapt. Ch.</b>                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pittsview Ala.</b>                             |  |                                                                                                                            |  |                   |  |
| 24. FUNERAL DIRECTOR<br><b>March Funeral Home</b><br>ADDRESS<br><b>4000 E. W. 11th St.</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grier</b>                                                                         |  |                   |  |

BP

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Vertical text on the right side, possibly a date or reference number.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

00958

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                  |                                                                                                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Earl Grier</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>83</b>        |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>8:58 AM</b>                                                           |                                                                                  |                                                                                                                                   |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b>                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>24</b> YEAR <b>14</b>                                                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b><br>IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                   |                                                                                  |                                                                                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                                                        |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                 | 13e. STREET ADDRESS<br><b>808 St. Paul Street 21202</b>                              |                                                                                  |                                                                                                                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Charles</b> LAST <b>Grier</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Louise</b> MIDDLE <b>Louise</b> LAST <b>Seed</b>           |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS <b>31520 Lucille White 916 Bartow St. Brunswick, Ga.</b>               |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5679</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>resp arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>peritonitis from leaking gastrostomy</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                      |  |
| 19a. DATE OF OPERATION<br><b>12-4-82</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>peritonitis</b> |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 9</b> , 19 <b>83</b> , to <b>Jan 9</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                            |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 22b. SIGNATURE<br><b>Wayne E. Ganes MD</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | DEGREE                                                                                          |                                                                                      | 22c. DATE SIGNED<br><b>1/9/83</b>                                                |                                                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wayne E. Ganes MD</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>Mercy Hosp</b>                                                               |                                                                                      |                                                                                  |                                                                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    | 23b. DATE<br><b>1/18/83</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cem.</b>                                    |                                                                                      | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co</b> STATE <b>Md.</b> |                                                                                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H Inc.</b> ADDRESS <b>1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE<br><b>JAN 17 1983 John J. Connel</b>     |                                                                                      |                                                                                  |                                                                                                                                   |  |

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1

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                   |        |                              |                                                                                                        |                                                                                                                                                          |                   |                                                               |                                                                     |                        |                                   |        |  |
|-------------------------------------------------------------------|--------|------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------|---------------------------------------------------------------------|------------------------|-----------------------------------|--------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                               |        |                              | 2a. DATE OF DEATH                                                                                      |                                                                                                                                                          |                   | 2b. HOUR                                                      |                                                                     |                        |                                   |        |  |
| FIRST                                                             | MIDDLE | LAST                         | MONTH                                                                                                  | DAY                                                                                                                                                      | YEAR              | HOUR                                                          |                                                                     | MIN.                   |                                   |        |  |
| ROBERT ALLEN GRONCKI                                              |        |                              | JANUARY 17, 1983                                                                                       |                                                                                                                                                          |                   | 11:10                                                         |                                                                     |                        |                                   |        |  |
| 3. SEX                                                            |        | 4. RACE                      |                                                                                                        | 5. DATE OF BIRTH                                                                                                                                         |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                                                                     | 7. IF UNDER 1 YEAR     |                                   |        |  |
| MALE                                                              |        | WHITE                        |                                                                                                        | JULY 6, 1948                                                                                                                                             |                   | 34                                                            |                                                                     | MONTHS DAYS HOURS MIN. |                                   |        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                         |        | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                     |                        |                                   |        |  |
| MARYLAND                                                          |        | U.S.A.                       |                                                                                                        |                                                                                                                                                          |                   | BALTIMORE CITY MD.                                            |                                                                     |                        |                                   |        |  |
| 10. CITY OR TOWN OF DEATH                                         |        |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                     |                        | 12b. KIND OF BUSINESS OR INDUSTRY |        |  |
| BALTIMORE                                                         |        |                              | THE JOHNS HOPKINS HOSPITAL                                                                             |                                                                                                                                                          |                   | BALTO. CITY P.B.O.                                            |                                                                     |                        | CITY GOV'T                        |        |  |
| 13a. STATE                                                        |        |                              | 13b. COUNTY                                                                                            |                                                                                                                                                          | 13c. CITY OR TOWN |                                                               | 13d. INSIDE CITY LIMITS?                                            |                        | 13e. STREET ADDRESS               |        |  |
| MO.                                                               |        |                              | BALTO.                                                                                                 |                                                                                                                                                          | PARKVILLE         |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        | 2822 ONYX ROAD 21234              |        |  |
| 14. FATHER'S NAME                                                 |        |                              |                                                                                                        |                                                                                                                                                          |                   | 15. MOTHER'S MAIDEN NAME                                      |                                                                     |                        |                                   |        |  |
| FIRST                                                             |        | MIDDLE                       |                                                                                                        | LAST                                                                                                                                                     |                   | FIRST                                                         |                                                                     | MIDDLE                 |                                   | LAST   |  |
| CARROLL                                                           |        | M.                           |                                                                                                        | GRONCKI                                                                                                                                                  |                   | BITTY                                                         |                                                                     | W.                     |                                   | POOLEY |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |        |                              | 16b. SOCIAL SECURITY NO.                                                                               |                                                                                                                                                          |                   | 17. INFORMANT ADDRESS                                         |                                                                     |                        |                                   |        |  |
| NO                                                                |        |                              | 21650 1151                                                                                             |                                                                                                                                                          |                   | FAMILY RECORDS                                                |                                                                     |                        |                                   |        |  |

|                                                                           |  |                                              |  |
|---------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:                                              |  |                                              |  |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>                       |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                            |  |                                              |  |
| (b) <u>Embryonal cell Ca of lung</u>                                      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                            |  |                                              |  |
| (c) <u>Teratoma of lung</u>                                               |  |                                              |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute myeloblastic leukemia

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                  |  |                                                                                                                                            |  |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                              |  |                                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                             |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                              |  | HOUR A.M. MONTH DAY YEAR                         |  |                                                                                                                                            |  |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION                                                                                                                              |  |                                                                |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> <u>1983</u> to <u>1/17</u> <u>1983</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>1/17</u> <u>1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                  |  |                                                                                                                                            |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                               |  | DEGREE                                           |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                               |  |
| <u>Marcelino D. Albuerne</u>                                                                                                                                                                                                                                                                                                                                 |  | MD                                               |  |                                                                                                                                            |  | <u>1/17/83</u>                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                        |  |                                                  |  | 22e. ADDRESS                                                                                                                               |  |                                                                |  |
| <u>Marcelino D. Albuerne</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  | <u>John Hopkins Hosp.</u>                                                                                                                  |  |                                                                |  |

|                                            |  |               |  |                                    |  |                            |  |
|--------------------------------------------|--|---------------|--|------------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE     |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION              |  |
| CREMATION                                  |  | JAN. 22, 1983 |  | GREENMOUNT CEM.                    |  | BALTIMORE MARYLAND         |  |
| 24. FUNERAL DIRECTOR                       |  |               |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE |  |
| NAME ADDRESS                               |  |               |  | JAN 27 1983                        |  | <u>John J. Givich</u>      |  |
| <u>EVANS FUNERAL CHAPL 8800 HARFORD RD</u> |  |               |  |                                    |  |                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  | REG. NO. 8300960                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Amelia Edna Gross                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 11, 1983                                                                                                     |  |                                                                                      |  | 2b. HOUR<br>12:13 P <sub>M</sub>                                                                                           |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 7, 1900                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Clerk     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Union                                                                                 |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Baltimore                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Paul Gross                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louisa Rebecca Luebeck                                                                                     |  |                                                                                      |  |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-01-7254                                                                 |  | 17. INFORMANT<br>ADDRESS<br>21214 Marie G. Bushman, 3414 Westfield Ave.                                                                                     |  |                                                                                      |  |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Dementia; Left Hemiplegia. Hypertension</u>                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>October 25</u> , 19 <u>82</u> , to <u>January 11</u> , 19 <u>83</u> that (X) (we) lost saw the deceased alive on <u>January 11</u> , 19 <u>83</u> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (we) did not see the body after death.                 |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |
| 22b. SIGNATURE<br><i>Cheryl Powell</i>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-11-83                                                          |  |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cheryl Powell, M.D.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |  |                                                                                      |  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>Jan. 14, 1983                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |  |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Joan L. Conner</i>                                  |  |                                                                                                                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  |                                                                                                                                                             |  | REG. NO.<br>83 00961                                                                                                       |                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. FOR-<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |                                                         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE L. LAST GROSS                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 6 83                                                                                                               |  | 2b. HOUR<br>9:45 AM                                                                                                        |                                                         |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>BLACK                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 14 29                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                                                                                 |                                                         |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>North CAROLINA                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                                                                     |                                                         |
| 10. CITY OR TOWN OF DEATH<br>BALTO                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MARYLAND HOSP |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED                                             |                                                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>BALTO                                                                                                                |  | 13c. CITY OR TOWN<br>BALTO                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Silas Spencer                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Plumie Knox                                                                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                      |  |                                                                                                                            |                                                         |
| 16b. SOCIAL SECURITY NO.<br>213-36-2622                                                                                                                                                                                                                                                                                                                        |  | 17. INFORMANT<br>ADDRESS<br>Robert Lockhart 1509 Edmondson Avenue                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4349 IMMEDIATE CAUSE (a) PROBABLE BRAINSTEM INFARCT<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.                                                                                                                                                                                                                            |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |                                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                                                                              |  |                                                                                                                            |                                                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                                         |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21, 1982, to 1/6, 1983, that (I) (we) last saw the deceased alive on 1/6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |                                                         |
| 22b. SIGNATURE<br>Howard Jacobs MD                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | DEGREE                                                                                                                                                      |  | 22c. DATE SIGNED<br>1/6/83                                                                                                 |                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOWARD JACOBS MD                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  | 22e. ADDRESS<br>22 S. Green ST 21201                                                                                                                        |  |                                                                                                                            |                                                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>1/11/83                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk.                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.                                                                  |                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. north avenue                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1983                                                                                                                 |  |                                                                                                                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |  | REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                                                     |  |                                                                                                                            |                                                         |

BP



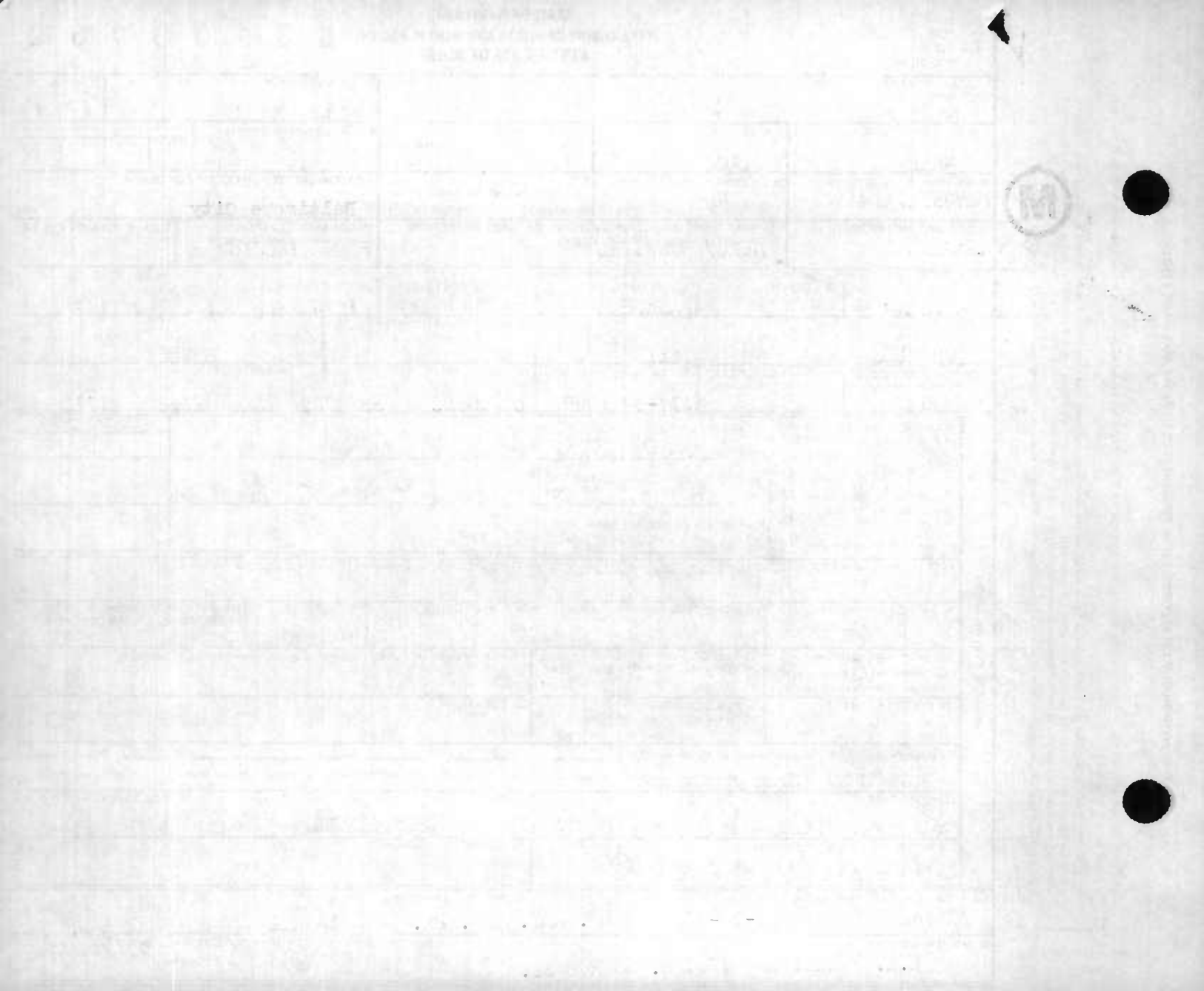
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the vital records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                      |  | 8 3 0 0 9 6 2                                                                                                                                               |  |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MILFORD GROSS                                                                                                                                                                                                                                                                                                                             |  |                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 12 83                                                                                                                 |  | 2b. HOUR<br>3 00 P.M.                                                                                                   |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>BLACK                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 22 36                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>46                                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>PENNSYLVANIA                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                              |                                              |
| 10. CITY OR TOWN OF DEATH<br>PASADENA                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL STREET ADDRESS)<br>MERCY HOSPITAL |  | 12a. USUAL OCCUPATION (GIVE FULL STREET ADDRESS)<br>FOOD DIRECTOR                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                      |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | 13c. STREET ADDRESS<br>7826 ISLE DRIVE 21122                                                                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CHARLES WILLIS                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BEULAH BUTLER                                          |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>217-34 1499                                  |  | 17. INFORMANT ADDRESS<br>LAUGENE GROSS 7826 ISLE DRIVE 21122                                                                                                |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Respiratory Arrest. Secondary to<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Brain - Metastasis from C. A.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) - lung. |  |                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)                                                                                                                                                                                                                                                             |  |                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                     |  |                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br>Shawki Malek M.D.                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                      |  | DEGREE<br>M.D.                                                                                                                                              |  | 22c. DATE SIGNED                                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHAWKI-N-MALEK                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                      |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>1-26-83                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MD. NAT. MEM. PK.                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>LAUREL MARYLAND                                                              |                                              |
| 24. FUNERAL DIRECTOR NAME<br>E.L. PHILLIPS                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                      |  | 24b. ADDRESS<br>1721 N. MONROE ST.                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1983                                                                            |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]                                                                                                           |  |                                                                                                                         |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  | 83 00963                                                                                                                                             |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  | REG. NO.                                                                                                                                             |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Christina Marie Groszer</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-23-83</b>                                                                                                |  |                                                                                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 4. RACE<br><b>WHITE</b>                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 2, 1896</b>                                                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>                                                                                                         |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON Medical Center</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                        |  | 13c. CITY OR TOWN<br><b>HANOVER</b>                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FREDERICK SCHUMAN</b>                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY RINEHART</b>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                                                                                                     |  | 13e. STREET ADDRESS<br><b>7237 FOREST AVENUE 21076</b>                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>212-54-9655</b>                                                                                            |  | 17. INFORMANT<br>ADDRESS <b>304 THACKERY, 21228</b><br><b>MRS. MADELINE G. FRAZIER, CATONSVILLE, MD.</b>                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) Pneumonia</b>                                                                                                                                                                                      |  |                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                         |  |                                                                                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral left hemiplegia &amp; CVA</b>                                                                                                                                                           |  |                                                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                        |  |                                                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 17, 1983</b> to <b>Jan 23, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Jan 23, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Julian W. Reed MD</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/24/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  | 22e. ADDRESS<br><b>511 S. CHAS. ST. 21238</b>                                                                                                        |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>1/27/83</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEMETERY</b>                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>DORSEY MARYLAND</b>                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL</b><br>ADDRESS <b>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>                                                                                                                                                                                                |  |                                                                                                                                           |  | 25. REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                                                                                        |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                   |  |                                                                                                                            |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00964

|                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                            |                                                                                                                                                             |                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                            | FOR                                                                                                                                                         |                                                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                            | FIRST MIDDLE LAST                                                                                                                                           |                                                                     |
| Charles Edward Grupp                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                                                                                             |                                                                     |
| 2a. DATE KNOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                      | MONTH DAY YEAR                                                                                             | 2b. HOUR                                                                                                                                                    |                                                                     |
| 1 9 19 83                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                            | 4:45                                                                                                                                                        |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          | 6. AGE (IN YEARS)<br>LAST BIRTHDAY                                  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                         | White                                                                                                      | 3-28-1916                                                                                                                                                   | 66 YRS.                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                          | U.S.A.                                                                                                     |                                                                                                                                                             | Baltimore City                                                      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                    | Baltimore City Hospital                                                                                    | Iron Worker                                                                                                                                                 | Local 16                                                            |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY                                                                                                | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?                                            |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                            | Baltimore                                                                                                                                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                              | 16. ADDRESS                                                                                                                                                 |                                                                     |
| Charles Grupp                                                                                                                                                                                                                                                                                                                                                                                                                                | Elsie Kratz                                                                                                |                                                                                                                                                             |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                    | 17. INFORMANT                                                                                                                                               |                                                                     |
| yes                                                                                                                                                                                                                                                                                                                                                                                                                                          | WW II                                                                                                      | Evelyn Grupp (wife) same address                                                                                                                            |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                 |                                                                                                            |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                           |                                                                                                            |                                                                                                                                                             |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                     |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                            |                                                                                                                                                             |                                                                     |
| ACTUAL SIGNATURE <u>Hormez R. Guard</u>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                          |                                                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                            | DATE SIGNED                                                                                                                                                 |                                                                     |
| Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            | 1/10/83                                                                                                                                                     |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                 | 23b. DATE                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1/12/83                                                                                                    | Parkwood                                                                                                                                                    | Baltimore Md.                                                       |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                            | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               | 25b. REGISTRAR'S SIGNATURE                                          |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                            | 212 JAN 11 1983                                                                                                                                             | <u>Jo Ann J. Connel</u>                                             |



RECEIVED  
JAN 10 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 6 5

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                            |                                                   |                                                                                                                                                             |  |                                                                                                                            |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY (PERRY) GRUSZCZYNSKI</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                            | 2. DATE OF DEATH<br>MONTH DAY YEAR <b>1/29/83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>12<sup>35</sup> AM</b>                                                                                      |                                                                                                |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>W</b>                                                                                                                                        |                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 27 02</b>                                                                                                           |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>81</b>                                                                             |                                                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                              |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>                                                          |                                                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSP. 108<sup>th</sup> BROADWAY</b> |                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                                |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                                                                                |                                                   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                                                |
| 13e. STREET ADDRESS<br><b>21224 606 S. MILTON AVE</b>                                                                                                                                                                                                                                                                             |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>STEPHEN KUCHTA</b>                                                                                            |                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                             |  |                                                                                                                            |                                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>212-42-3402</b>                                                                                                             |                                                   | 17. INFORMANT<br>ADDRESS<br><b>BERNADINE BORDOWY 624 S. MILTON AVE</b>                                                                                      |  |                                                                                                                            |                                                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149 IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Intractable Congestive Heart failure</b>  |  |                                                                                                                                                            |                                                   |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR.</b><br><b>10 yrs</b><br><b>10 yrs</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Severe Osteo-Arthritis.</b>                                                                                                                                                                 |  |                                                                                                                                                            |                                                   |                                                                                                                                                             |  |                                                                                                                            |                                                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          |                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |                                                                                                |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                            |                                                   |                                                                                                                                                             |  |                                                                                                                            |                                                                                                |
| 22b. SIGNATURE<br><b>M. N. Khan</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                            |                                                   | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>1-29-83</b>                                                                                         |                                                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. N. KHAN</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                            |                                                   | 22e. ADDRESS<br><b>2711 Eastern Ave. Balto-21224</b>                                                                                                        |  |                                                                                                                            |                                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>PROPERTY<br><b>BURIAL</b>                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>2/2/83</b>                                                                                                                                 |                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy ROSARY</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                                                          |                                                                                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RAYMOND L. KACZOROWSKI 2525 FLEET ST.</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                            |                                                   | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 2 1983</b>                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |                                                                                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

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CHIEFTAIN

20% COTTON FIBRE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 6 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Rose Agnes Guckert</i>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1-8-83</i>                           |                                                                                                                                                             |                                                                                | 2b. HOUR<br><i>7:35 P.M.</i>                                                                                                               |                                                                                                 |                                                                                                                            |                                                                  |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><i>White</i>                                                                                                                          |                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 31, 1927</i>                                                                                                   |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>55</i> YRS.                                                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                       |                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                                                          |                                                                                                 |                                                                                                                            |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Deaton Med Center Balto. Md.</i> |                                                                             |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                                       |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                  |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  | 13b. COUNTY<br><i>---</i>                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br><i>Baltimore</i>                                          |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><i>1625 Clarkson St. Balto. Md. 21230</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Paul F. Colmus</i>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rosekla --- Unknown</i> |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><i>216-24-8992</i>                              |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><i>Mr. Matthew L. Guckert, Same as above</i>       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arterio-sclerotic Cardio Vascular</i><br><i>4360</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial Infarction</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebro Vascular Accident bilateral</i><br><i>1981</i> |  |                                                                                                                                                  |                                                                             |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><i>Sick Sinus Syndrome &amp; Pacemaker, Neurogenic Bladder</i>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                                                             |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-8-83</i> , to <i>1-8-83</i> , that (I) (we) last saw the deceased alive on <i>1-8-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                              |  |                                                                                                                                                  |                                                                             |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 22b. SIGNATURE<br><i>Rolando V. Gou, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  | DEGREE                                                                      |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><i>1-5-83</i>                                                                                          |                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  | 22e. ADDRESS                                                                |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><i>Jan. 13, 1983</i>                                                                                                                |                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Cross Cemetery</i>                                                                                            |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>                                                                    |                                                                                                 |                                                                                                                            |                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McGully Funeral Home. 130 E. Fort Ave. Balto. Md.</i>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><i>21230</i>                                                                                                               |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SAM JOSEPH Gugliuzza                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 24 1983                           |                                                                                | 2b. HOUR<br>1:20 A.M.                                                                                                      |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>WHITE                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 23, 1904                                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                  |                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |                                                                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Jenkins Memorial Home<br>1000 S. Caton Ave. 21229 |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL TIRE                               |                                                                                                                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                     |                                                                                                              |                                                                                                                                                             | 13b. COUNTY<br>--                                                           | 13c. CITY OR TOWN<br>BALTIMORE                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CARMELE GUGLIUZZA                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANGELINA MATASSA           |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                |                                                                                                              | 16b. SOCIAL SECURITY NO.<br>215-09-4539A                                                                                                                    | 17. INFORMANT<br>ADDRESS<br>JOSEPHINE C. GIORDAN SAME AS # 13               |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CVA - R hemiplegia</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                              |                                                                                                                                                             |                                                                             |                                                                                |                                                                                                                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                    |                                                                                                              |                                                                                                                                                             |                                                                             |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                              |                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                          |                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-27-82</u> , 19 <u>82</u> , to <u>1-24-83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-27-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                           |                                                                                                              |                                                                                                                                                             |                                                                             |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>Angela</u>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                             | 22c. DATE SIGNED<br>1-24-83                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE ANGOL                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                              | 22e. ADDRESS<br>3350 Wilkens Dr. Balti Md                                                                                                                   |                                                                             |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                              | 23b. DATE<br>1/27/83                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN CEMETERY                   |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MD.                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEROY M. & RUSSELL C. WILKE FUNERAL                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              | ADDRESS<br>1630 EDMONDSON AVENUE, CATONSVILLE, MD, 21228                                                                                                    |                                                                             | DATE REC'D. BY REGISTRAR<br>JAN 26 1983                                        | REGISTRAR'S SIGNATURE<br><u>John J. Connelley</u>                                                                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

HOME 23 NOV 1954

LISTED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                   |  |                                                                                                                                                     |                                                              |                                                                                                                                                             |                                                                                                 |                                                                             |  |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MERRITT DOUGLAS GUNTER                                                     |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 20 83               |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br>6:30P M                                                         |  |                                                 |  |
| 3. SEX<br>M                                                                                                       |  | 4. RACE<br>WHITE                                                                                                                                    |                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 7 1931                                                                                                              |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                                  |  |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Colorado                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                 |                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |  |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VETERANS ADMINISTRATION MEDICAL CENTER |                                                              |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>ENGINEER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ELECTRICAL |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |  |                                                                                                                                                     | 13b. CITY OR TOWN<br>Annapolis                               |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                             |  | 13e. STREET ADDRESS<br>1141 MAINSAIL Dr. 21403  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VERNON L. Gunter                                                        |  |                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisy Kelso |                                                                                                                                                             |                                                                                                 |                                                                             |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1948-1952                                                                                |                                                              | 17. INFORMANT<br>Niha B. Gunter                                                                                                                             |                                                                                                 | ADDRESS<br>#13                                                              |  |                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

5715 IMMEDIATE CAUSE (a) hepatorenal syndrome

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) staphylococcal sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

10 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

severe hepatic cirrhosis with encephalopathy, ascites

|                                                                                                                                                          |  |                                                                                |  |                                                                                      |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>12/13/82                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>degenerative joint disease |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 8, 1982, to JANUARY 20, 1983, that (I) (we) lost saw the deceased alive on JANUARY 20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                                                 |  |  |                                                         |  |  |
|-----------------------------------------------------------------|--|--|---------------------------------------------------------|--|--|
| 22b. SIGNATURE<br>Darla S. Holland, M.D.                        |  |  | 22c. DATE SIGNED<br>1/20/83                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DARLA S. HOLLAND, M.D. |  |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto., Md. 21218 |  |  |

|                                                        |  |                      |  |                                                    |  |                                                                     |  |
|--------------------------------------------------------|--|----------------------|--|----------------------------------------------------|--|---------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>1/25/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md Vet. Cemt |  | 23d. LOCATION<br>(CITY OR TOWN COUNTY STATE)<br>Crownsville PA M.D. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>TAYLOR FUNERAL CHAPEL  |  |                      |  | ADDRESS<br>Annapolis Md.                           |  | 25. DATE REGD. BY REGISTRAR<br>JAN 26 1983                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the original and a copy of this certificate for the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Please retain the original and a copy of this certificate for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the original should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

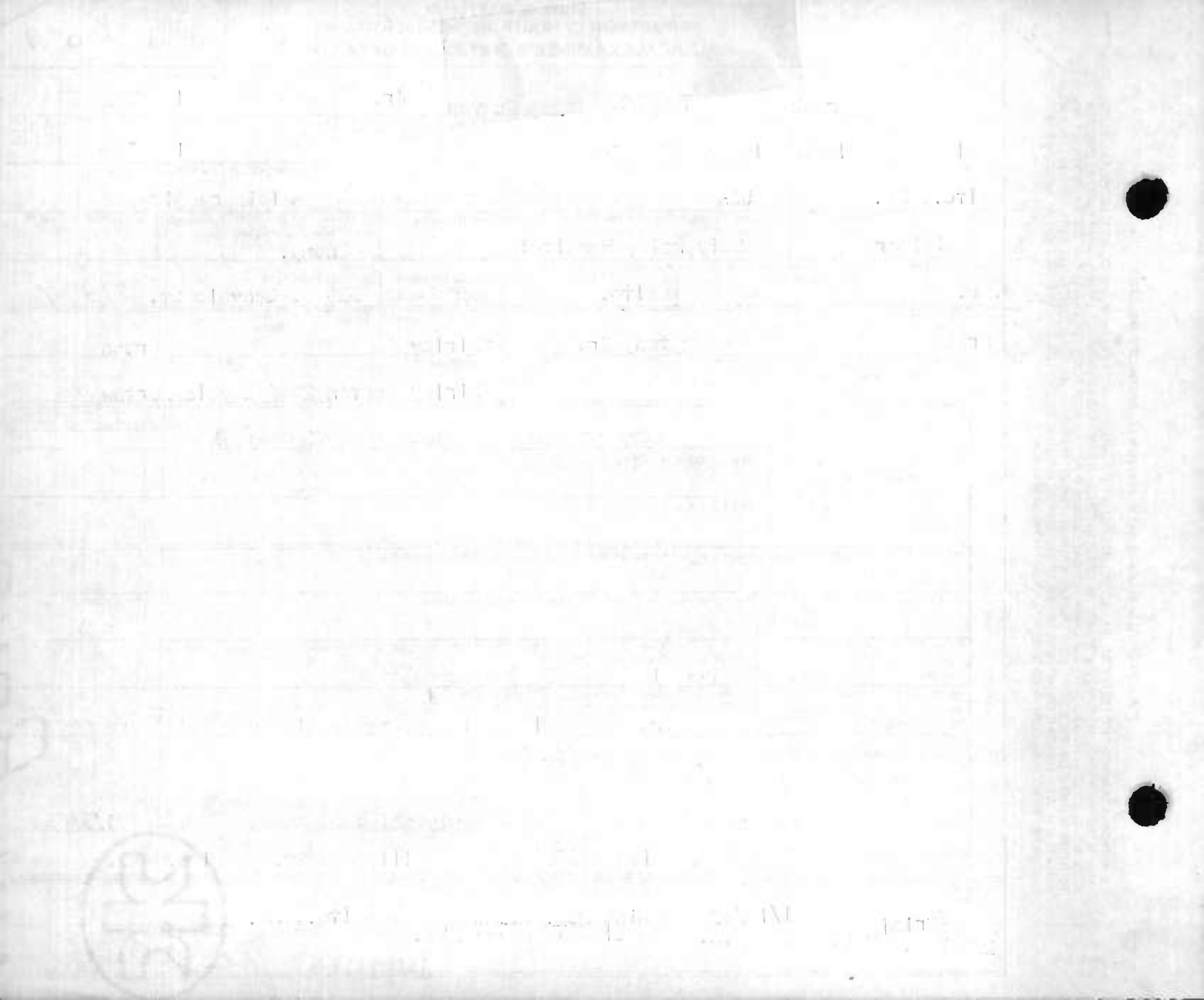
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |                |                                                                                                                                   |  |                                                                       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|----------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  | FIRST<br>Frank |                                                                                                                                   |  | MIDDLE<br>THOMAS                                                      |  |                                                                                                                                                          | LAST<br>Gupton Jr. |                                                                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 2 19 83                                  |  |                                                           |  | 2b. HOUR<br>M<br>8:50<br>A                   |  |  |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>Black |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 3 53                                                                                     |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>29 YRS.                         |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                            |                    | IF UNDER 24 HRS.<br>HOURS MIN                                           |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 2 19 83                                              |  |                                                           |  | 2d. HOUR<br>M<br>8:50<br>A                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  |                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                          |  |                                                           |  |                                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |                                                                       |  |                                                                                                                                                          |                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemp. |  |                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |                                              |  |  |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                  |                | 13b. COUNTY                                                                                                                       |  | 13c. CITY OR TOWN<br>Balto.                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                          |                    | 13e. STREET ADDRESS<br>520 W. Lanvale St. 21217                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Gupton, Sr.                                                                                                                                                                                                                                                                                                                                                                              |  |                  |                |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Shirley Green        |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                              |  |                  |                | 16b. SOCIAL SECURITY NO.                                                                                                          |  | 17. INFORMANT<br>ADDRESS<br>Shirley Gupton 2406 Loyola Northway       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9650 IMMEDIATE CAUSE (a) Gunshot wound of abdomen (handgun)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                               |  |                  |                |                                                                                                                                   |  |                                                                       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                  |                |                                                                                                                                   |  |                                                                       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                |                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |  |                                                                                                                                                          |                    |                                                                         |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |                                                           |  |                                              |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                  |                |                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:31 PM 1 2 19 83  |  |                                                                                                                                                          |                    |                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot        |  |                                                           |  |                                              |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                |  |                  |                |                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |  |                                                                                                                                                          |                    |                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1000 Blk. Pennsylvania Ave. Baltimore City, Md. |  |                                                           |  |                                              |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                |                                                                                                                                   |  |                                                                       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |                |                                                                                                                                   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                                  |  |                                                                                                                                                          |                    |                                                                         |  | DATE SIGNED<br>1/3/83                                                                                |  |                                                           |  |                                              |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |                |                                                                                                                                   |  | ADDRESS<br>111 Penn St. Balto., MD.                                   |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                |                                                                                                                                   |  | 23b. DATE<br>1/12/83                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.                                                                                                      |                    |                                                                         |  |                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |  |                                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>LEROY O. DYETT & SON F.H. 4600 LIBERTY HTS. AVE. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br>JAN 10 1983 John J. Carver                                                                                                                                                                                                                                                                                    |  |                  |                |                                                                                                                                   |  |                                                                       |  |                                                                                                                                                          |                    |                                                                         |  |                                                                                                      |  |                                                           |  |                                              |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 3 0 0 9 7 0

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      |                                                                                                                                                            |                                                                                                 |                                                                                     |                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JEAN Aaron GLITMAN                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>1 9 83<br>4 02 20 7:45 AM                                 |                                                                                     |                                                |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4 RACE<br>WHITE                                                                                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 02 20                                                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                       |                                                                                     |                                                |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York City                                                                                                                                                                                                                                                                                                                                                                                                            | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                        |                                                                                     |                                                |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Manager              |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br>S & N Katz |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY                                                                                                                          | 13c. CITY OR TOWN<br>Baltimore                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>2808 Louise Ave 21214                                         |                                                |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aaron Gutman                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Neubauer                                                                                              |                                                                                                 |                                                                                     |                                                |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-10-8138                                                                                     |                                                                                                 | 17 INFORMANT<br>ADDRESS<br>Mrs Betty L Gutman Same                                  |                                                |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HYPOXIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>LUNG CANCER, TUBER</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>?<br>DX - 1 YEAR |                                                                                                                                      |                                                                                                                                                            |                                                                                                 |                                                                                     |                                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>TUBERCULOSIS</u>                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                            |                                                                                                 |                                                                                     |                                                |
| 19a DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                                                      |                                                                                                 | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>NA<br>P.M. 19                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>— |                                                |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—                                                                                |                                                                                                 | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>83</u> , to <u>1/9</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>7:40 1/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                                                                                            |                                                                                                                                      |                                                                                                                                                            |                                                                                                 |                                                                                     |                                                |
| 22b SIGNATURE<br><u>D. Weinreich</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | DEGREE<br><u>MD</u>                                                                                                                                        |                                                                                                 | 22c. DATE SIGNED<br><u>1/9/83</u>                                                   |                                                |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 22e ADDRESS                                                                                                                                                |                                                                                                 |                                                                                     |                                                |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECKY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 23b. DATE<br>1/11/83                                                                                                                                       |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem Park                             |                                                |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J Ruck Inc. Baltimore, Maryland                                                                            |                                                                                                 |                                                                                     |                                                |
| 25a DATE RECORDED BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 25b REGISTRAR'S SIGNATURE<br>JAN 10 1983 <u>John J. Canick</u>                                                                                             |                                                                                                 |                                                                                     |                                                |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

83 00971

REG. NO.

|                                                              |                                                                                              |                                                                                                                                                             |                                                                |                                                                                   |                                                                 |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLADYS V. GUY</b>  |                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 13, 1983</b> |                                                                                   | 2b. HOUR<br><b>12:45</b>                                        |
| 3. SEX<br><b>Female</b>                                      | 4. RACE<br><b>White</b>                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 2, 1895</b>                                                                                                   |                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b> | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             |                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                 |
|                                                              |                                                                                              |                                                                                                                                                             |                                                                |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                |

|                                                                                   |  |                                                                               |                                                                        |                                                                        |                                                                                                 |                                                         |
|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 13a. STATE<br><b>Maryland</b>                                                     |  |                                                                               | 13b. CITY OR TOWN<br><b>Baltimore</b>                                  | 13c. ZIP CODE<br><b>21204</b>                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1310 Providence Rd. 21204</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Joseph Bayne</b>             |  |                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ann Simms</b> |                                                                        |                                                                                                 |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-48-9843</b> |                                                                        | 17. INFORMANT ADDRESS<br><b>Merle V. Guy 1310 Providence Rd. 21204</b> |                                                                                                 |                                                         |

|                                                                                                                                                                                                                                                                                                                                                                                             |  |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br><b>2398</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Thoracic Tumor**

|                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>1/5/83</b>                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>11</b>          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12/83</b> to <b>1/13/83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/12/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>R. J. Davis M.D.</b>                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                 |  | 22c. DATE SIGNED<br><b>1/13/83</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Davis</b>                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS                                                           |  |                                                                                      |                                                                                                                            |

|                                                            |                                  |                                                                                       |                                                     |
|------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>Jan. 16, '83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Providence U.M. Church Baltimore Co., MD</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |                                  | ADDRESS<br><b>8521 Loch Raven Blvd.</b>                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b> |
|                                                            |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                   |                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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